Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00001 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ADEPO Physician/ 0630 Medical 4d. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death House Anne Arundel Tate Linthicum 8. Date of Birth (Month, Day, Yea Tan 24, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Africa **Funeral** 1 🗆 M 2 🗹 F Months Days Hours Min 1941 Director 68 218-51-0775 Usual Residence of Decedent 28a-f shov 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Laurel 1 🗆 Yes 2 🏝 No Maryland Howard 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 20723 United States 8316 Sperry Court items ; 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Deceud. ed Forces? Yes 2 No rmed Fo Black, White, etc. ō 1 Never Married 2 Married Completed by Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. 'natural", Specify Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 72 (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Corrections Corrections Official Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sanusi Talabi unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 shiment of Health a tant: If item 27 is jury or other tra 8316 Sperry Court, Laurel, Maryland 20723 Lola Kellum/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ot 20c. Location - City or Town, State January 5. 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 2010 Baltimore, Maryland Metro Crematory, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death Immediate Cause (Final Pnysician/ LUNG disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events burial-tran and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Dav Yea 5 Other (specify) Pregnant at time of death the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Certificate: To 1 🗌 Yes Other: HOSPICE 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home this 5 Residence funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 41 U1 SE Natural 5 Pending injury 24 hours after death. Funeral Director; A 1 ☐ Yes 2 ☐ No Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 21438 ANNAPOLIS MOZIYOI 1) EFENSE HIGHWAY MICHAR a 亡

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00002 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Reba A. Atwood IWA 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Franklin Squar Rosedale conte HOSpita If Under 1 Year | If Under 24 Hrs. (State or Foreign Social Security Number 7. Age (In vrs. last birthday) (Month, Day, Year) April16,193 Days Hours 1 M 2 KF 78 224-32-4608 WVA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Baltimore MD Middle River 1 ☐ Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 9756 Matzon Road USA 21220 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 TNo White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 7th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maggie Beavers Clinton B. Rose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mack J. Atwood Sr./husband 9756 Matzon Road Balto. MD 21220 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a Method of Disposition cemetery, crematory or other place)
Holly Hill Cemetery Burial 2 ☐ Cremation 3 ☐ Removal from State 1/5/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Signature of Funeral Service Licenses 21221 Connelly Funeral Home of Essex COL Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or course actions that caused are death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each lim. Immediate Cause (Final SEPSIS resulting in death) Du to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. lascular Distase 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably

Examiner executed Box 68760 certificate be P.0. Division of Vital Records, or Attending To the Hospital

sician and burial-trans attending physician the as asn ō the signed by has certificate this After after death.

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**Examiner** 

**Funeral** 

Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. "natural", or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mexical Exemple or nails to rollified at

**Physician** 

/Medical

Atwood Keou Baltimore, Maryland 21215-0036

filled in by within 24 hours a

		24a. Was an autopsy performed? performed? 1 □ Yes 2 ☑ No
25. Was case referred to medical	26. Place of D	eath (Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work?  M 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a, Certifier 1 Certifying P	hysician: To the best of my knowledge, death occurred at the time, date and pla	ace, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Franklin Square Drive Baltimore, MD

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

JAN 05

Registrar's Signatur

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 9104 AM MARIE BROWN ELMA 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CARROLL CARROLL HOSPITAL CENTER WESTMINSTER Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1□M 2 💆 F Months Days Hours 9151 24 6 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Wedgal Evander must be notified at 1 Yes 2 No Director MO HOWARD ELLICOTT 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number SA 2288 CARROLL MILL ROAD 21042 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2Y No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No Specify: Specify: BLACK 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) GENERAL Elementary/Secondary (0-12) College (1-4or 5+) MOTORS ELECTRONIC SOLWERER marked other tumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CAMILLE 27 is marked traumatic e BOUDREAUX 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) t of Health a RALPH BROWN 12288 CARROLL MILL ROAD ELLICOTT CITY MO 21042 Department of Health Important: If item 27 any injury or other the once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 4/2010 WINFIELD, MO South CARROIL Crein 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J N Zum Brun It & row Co 21. Signature of Funeral Service Licensee 23a. Reft 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SYKESVILLE RO ELIDERS BURG MO 21784 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** Acute Me /Medical Examiner Acute Eleucienhe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for an expectation of the funeral director. Due to (of as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 █ No Month Year Day 5 ☐ Other (specify) 9 Dunknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Time Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

State

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item P3a) (Type, Print)

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JAN 05

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #10b,c&d& 29d PerPhy&FH C899 1/05/10 JH
State of Maryland / Department of Health and Mental Hygiene 2 0 0 0 0 0 4

		•	For State Registrar	•	Certificate of Death	Reg. N	lo.	
			1. Decedent's Name (First, Middle, Last)			2. Date of Death Month D	ay Year	3. Time of Death
	Physicia /Medic		Leo Melvin Bolyard			January	,	2:30 A M
1	Examin		4a. Facility Name (If not institution, give street and number		4b. City, Town, or Location of Deat		c. County of Death	
-	.,		Bayview Medical Cente		Baltimore Ci		L O Binth	In a Chata as Casaign
	Funeral Director		5. Social Security Number  212.34.449  Usual Residence of Decedent	Age (In yrs. last bi	Yrs. Months Days Hours Min.	(Month, Day, Yea	n) 9. Birthpi Coun	lace (State or Foreign try)  WV
	and and	1	10a. State 10b. County	10c. City, Tow	n or Location		10	0d. Inside City Limits
	he Maryl 28a-f sho offilioù a	ector	MD Battimore  10e. Street and Number	Balt	Baltimore (		Citizen of What Coun	Yes 2 No
	ath with t	Funeral Director	5 North Kresson St		21224		USA	
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Уa	should to and Men some marker umatic	မ	Cleofus Melvin Bolyar			Newland		
Nar			19a. Informant's Name/Relationship (Type. Print)	1	b. Mailing Address (Street and Number or R N. Kresson St.,			
e,	s 1 and of Health item 27 other to		June Braun - Companio 20a. Method of Disposition		of Disposition (Name of ery, crematory or other place)		Location - City or To	
nor	00		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta		ery, crematory or other place) riew Crematory, 1-8	3 2010 Ba	ltimore	МЪ
	permit. Pag Department Important: i any injury o		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	bayv	OO Name and Address of English			
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<u>~</u>	Physician: this certifice al director, p		1 Yes 2 No Hospital: 1 Inp			Home <del>3 Mesi</del> dence	6 ☐ Other (Specif	fy)
Division of Vital Records,	ding Ph h. After th funeral	Certification: To	1 12 Natural 5 Li ending	njury Day, Year) 28b.	Time of Injury at Work?  M 1 Yes 2 No	28d. Describe how in	jury occurred	
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	To the Hospital or Attending Physician: within 24 hours After dean. To the Funeral Theoton After this certified completely filled in by the funeral director, p	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the base and mannel	s of examination a	ge, death occurred at the time, date and pla and/or investigation, in my opinion, death occ	ce, and due to the cause curred at the time, date	ə(s) and manner as s and place, and due t	stated. o the cause(s)
	To the comp	ž	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month,	Day, Year) 2010
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V	Y		30. Name and address of person who completed cause of Maresh Khane Ho	901 Ec	(Type, Print)  Seen Buleard	Beltmore	MO 21	27.1
	Sta		31. Date filed (Month, Day, Year) 82 Reg	istrar's Signature				
	Registr	ar	JAN 0 5 2010 Chrena	B. 1	and the second			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month М 2010 January 0441 Henry Cov1e Boyce Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth X M 2 □ I Days Hours Month Day y April II Year) 1,1924 Washington, D.C. Min 118-16-7543 Director 85 Usual Residence of Decedent 28a-f show 10a. State 10b. County items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1X Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 131 South Adams Street 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner 6 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Specify: 3 X Widowed 4 Divorced Completed White Year or Dates. WWII Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. lant; If Item 27 is marked other than "natus ury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ College Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Samuel Edwin Boyce, Jr. Ethel Coyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda MacDermid 1019 Kennon Court, Rockville, <u>Maryl</u>and 20851 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State January 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 2010 Silver Spring, Maryland Signature of Funeral Service Dicensee Robert A. Fumphrey Funeral Home/Rockville, 300 West Montgomery Avenue, Rockville, Maryland 20850-M01360 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Non St Elevation Myocardial Infarction Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading immediate cause. Enter Underlying Cause (Disease or iinjury that in its total cause to the cause of injury that in its total cause in its cause or injury that in its total cause in its cause of injury that in Due to for as a consequence of Exami burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? certificate Yes Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 X No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending work' 1 Yes 2 🗌 No after death. Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours a To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

State

DHMH 17 Rev 7/2009

Registrar

(Check

29b. Signature and title of certifier

<u>John Soma, M.D</u> 31. Date filed (Month, Day, Year,

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

9901 Medical Center Drive, Rockville, Maryland 20850

D0067386

29d. Date signed (Month, Day, Year)

January 2, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month BECHTEL **Physician** 2010 01 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Rosada If Under 1 Year Hospita Center Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days **1**XM 2□ F Months 09/18/1930 212-28-1931 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 🛣No Director Baltimore Overlea Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò United States 21236 227 Sipple Avenue 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items 11. Marital Status 1 XYes 2 No If Yes, Give 1 ☐ Never Married 3 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ Specify: White 3 Widowed 4 Divorced Year or Dates: 48–51 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) should be filed within than College (1-4or 5+) Elementary/Secondary (0-12) Automotive Spray Painter +2 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Jennie Reading Howard L. Bechtel ပ injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health attem 27 is 4322 Hampton Court Riverside, Maryland 21015 Jay E. Bechtel - Son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages '
Department of I
Important: If ite
any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 01/04/2010 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 Approximate Interval Between 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final SEPSIS Physician resulting in death) /Medical Due to (or as a consequence of): Examiner NEUMONIA Sequentially list conditions, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Ves 2 No 3 Probably 4 Unknown Completed ULCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2-1No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 (Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide e Funeral I 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar 29b. Signature and title of certifier

and manner stated.

29d. Date signed (Month, Day, Year)

within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 09:594 BOYD Eileen 03-2010 01-/Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltmore Shak-Trauma Center University of Wayland If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Date of Birth 5. Social Security Number 6. Sex **Funeral** Hours 08/11/1938 Months Days Min. 1 □ M 2 🎗 F 217-34-3440 MD Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.

27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experience of the country of the market of the medical Experience of the country of the medical Experience of the medical Experienc 1 X Yes 2 □ No Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 4307 Greenhill Avenue 21206 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: <u>}</u> White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bangs Marv Ruby 2 Edward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sl Department of Health an Important: If item 27 Is I any injury or other trau 2838 Lake Avenue, Baltimore, MD 21213 Howard A. Boyd, III Saltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/8/10 Garrison Forest Veterans 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Ufordia Blan 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 12 days **Physician** /Medical Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner pue to for as a consequence off. the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 ☐ Other (specify) P.0. ed by the detached i 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ✓ No 3 ☐ Probably 4 ☐ Unknown Coronary Artery disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, F. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 🗹 No 12-22-2009 ~ 15:30 M Sliged on at 2 Accident Ice 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)
4307 Greenhill Avenue, Baltin 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 01-03-2010 MD 30. Name and address person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Greene

3.

32. Registrar's Signature

MD

TIMMONS

31. Date filed (Month, Day, Year)

JAN 0 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 2 per dr., 8900,02/01/2010dnb 00008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 01/02/2010 3. Time of Death Physician/ January 3. 2010 4:50P GABRIEL CREAGHAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St Elizabeth Nursing Center Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√√ F January 22, 1911 Marviand 218-40-1039 98 **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes XX No Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3310 Benson Avenue 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black White etc. XX Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Librarian Parochial School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Augustine Joseph Creaghan Loretto Flannery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol A Mantz 9233 Bellbeck Road Baltimore, Maryland 21234 Niece Method of Disposition

We Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State St Charles Borromeo Cemetery Jan 5,2010 Pikesville, Maryland 4 Donation 5 Other (Specify) gnature of Funeral 22. Name and Address of Facility Mitchell-Wienereld Funeral Home Inc unw 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Year S Immediate Cause (Final enysician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Failure to Thrive Years Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Anemia XX No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2XXNo 1 🗌 Yes 2 🗆 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? 2 **XX**0 Hospital Other: XX Nursing Home 5 - Residence 6 - Other (Specify) 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D55391 January 4, 2010

State

Registrar

aske

Ming Yi, MD 3320 Benson Avenue Baltimore, Maryland 21227

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00009 Reg. No. U Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 3rd 2010 01:10PM **Physician** anvari William B. Clark, Jr. /Medical 4c. County of Death 4b Gity, Town or Location of Death" 4a. Facility Name (If not institution, give street and number Examiner N/A aint Agnes altimore 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Dec. 3, 1929 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours 1 <del>∏</del> M 2 □ F Months Days Maryland Yrs. 215-28-9576 80 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County d other than "natural", or items 23a or 28a-f show event, the Madieni Examinar must be notified at 1 □ Yes 2 □ No Director Halethorpe Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21227 5558 Southwestern Blvd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Army 11 Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: White 1 □Yes X□No Maryland 21215-0036 If Yes, Give Year or Dates: Korea þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) ADT Security Security marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked offit any light yo other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Helen Voelker William B. Clark, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5558 Southwestern Blvd., Halethorpe, MD 21227 Constance C. Clark - Wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 1-7-2010 Brooklyn Park, MD Holy Cross Cemetery Other (Specify) 4 □ Donation 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licens 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) remia-**Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Myocardiai William and Due to (or as a consequence of): burial-.\Qr K, WIIII4! physician Physician/Medical the as attending properties for use as 23d. Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Dav in the past 12 months? 5 Other (specify) □Yes 2□No the 9 I Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ∰No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2**X**00 certificate Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Phpatient 2 ER/Outpatient 3 DOA 1 | Yes 2 | 300 Certification: To funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After Injury Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide In Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical | Continued on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print) Caton Ave. Baltimore, HD Morales-1612 900

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

IAN 0 5 2010 Burns A Source

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 0619 AM Janvar 07 2010 Medical Town, or Location of Death Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 2100 Memoria 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Director "natural", or items 23a or 28a-f shov idical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County should be filed within 72 hours after death with the Maryland Director 1 XYes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. Yes 2 No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify. 3 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) oday (0-12) Be 17. Father's Name (First, Middle, Last) ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21209 Date 20b. Place of Disposition (Name of 20c Location - City or Town, State 20a. Method of Disposition -1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician HOUS Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the bunal-transit Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Pregnant at time of death signed by the a Id be detached for Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes Records, eral Director. After this certificate has been si filled in by the funeral director, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 2 🗎 No Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: iniury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: At ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated сопрете 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number MO 02 2010 00053373 Janvary 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Orion Memorial 1Saltimore Month, Day, Year)
JAN 0 5 2010 31. Date filed (Mo Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Cooney January Offay 2010 Μ. 10:30 pm Mary Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore 3900 N. Charles St. #901 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** an 15, Year 916 Months Days Hours Min. 1 🗆 M 2 😿 F MaryTand 93 Jä'n 217-20-8926 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Director 1 X Yes 2 □ No N/A Baltimore Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21218 3900 N. Charles St. #901 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) . DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Art Gallery Treasurer +4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Μ. Gunther Marv Cooney William L. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sparks, Md. 21152 item 27 Ms. Eileen Weglein/ Niece PO Box 1094 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ott cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State New Cathedral Cem. 1-6-10 Baltimore, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Seurce Incense 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson. 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2 week disease or condition resulting in death) Medical Due to (or a a consequence of): Examiner Duy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): physician by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ed by the atter in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed the should be det 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Certificate: To Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of s certificate has b director, page 2 si autopsy performed. death? 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After injury work? 1 \sum Yes 2 \sum No 1 X Natural 5 Pending Investigation Accident within 24 hours after death

To the Funeral Director: /
completed filled in by the f 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or 29b. Signati d title of certifia 29d. Date signed (Month, Day, Year) hd address of person who completed cause of death (Item 23a) 30. Name a

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month. Day, Year)

JAN 0 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 6:00 AM January 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimoro Hospital Cof altemore Since last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month Day, Year 6 Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Days Months Hours 120-30-1268 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Director timore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21215 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever II U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Newer Married 2 Married 21215-0036 2 No Specify. 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 2 should be filed within 72 h and Mental Hygiene.
7 is marked other than "r College (1-4 or 5+) Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or other traumatic e Gran 19a. Informant's Name/Relationship (Type, Print) Town, State, Zip Code) al Route Number, City o 19b. Mailing Address (Street and Number or R Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Baltomi Hodg 23a. Part 1. Enger the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Preumonia Medical resulting in death) Due to (or as a consequence of): Examiner Obstantive Pulmonary Sequentially list conclitions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be e attending pl IF FEMALE: res, outcome of pregnancy
Live Birth 2 - Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 🗌 in the past 12 months?
1 ☐ Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death been signed by the should be detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Measil cate has t page 2 s autopsy death? 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 🗌 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No injury 5  $\square$  Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 19620 January MBBS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore, 2401 W Behredore Av, Baltimore, MD 21215 , M18BS DR. SUMIT KAPOOR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 4 2010 Registrar

Chambery, Magry

Potrent

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2010 Physician/ 1:00 AM lan Medical 4a. Facility Name (if not institution, give street and no Town, or Location of Death 4c. County of Death **Examiner** Baltimore Lexina せつつ Stree If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 93 Yrs. If Under Social Security Numbe **Funeral** 10.23 1916 Months Davs Hours Country) 1 **M** M 2 □ F Director ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** 1 es 2 No more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21223 permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner museonce. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done the. DO NOT use retired (Specify only highest grade completed) Baltimore, Maryland 2121 Elementary/Seconday (0-12) ege (1-4 or 5+) Be her's Name (First, Middle ည or Town, State, Zip Code, 20c. Location - City or Town, State Place of Disposition (Name of 20a, Method of Disposition cemeter ry or oth 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the m shock, or heart failure. List only one cause or ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No cate has been signed by the page 2 should be detached Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ρ 2 → No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ည within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 5 Pending Natural Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated сотрыетер Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License numbe 30. Name and address of per of death (Item 23a) (Type, Print) AVE COMMONWESTA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Chaney Physician/ Raymond Bruce Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Center Towson Joseph Medical 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days Hours Min. (Month, Day, West Virginia 1 ፟፟፟፟ M 2 □ F 86 218-16-3864 Director Usual Residence of Decedent 10d. Inside City Limits 23a or 28a-f show 10b. County 10c. City. Town or Location is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2XX No Baltimore Parkville MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21234 Funeral 8810 Walther Blvd. Apt. 1604 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. W Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes ŽĮĮNo Specify: Specify: 3XXWidowed 4 ☐ Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 2 should be filed within 72! the and Mental Hygiene.
7 is marked other than "n College (1-4 or 5+) Elementary/Seconday (0-12) Marine Superintendent Steamship Company 12 Years Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Katherine Kemph George Chaney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10023 Clue Drive Bethesda, Maryland permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Mr. David J. Chaney (Son) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Towson, Maryland Service Corp. 1/8/2010 4 ☐ Donation 5 ☐ Other (Specify) Hilltop <sup>22</sup> Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 21. Signatur e of Funeral Service Licensee Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Dule to (or as a consequence of). resulting in death) Medical **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Year Month Day in the past 12 months? signed by the and be detached for Yes 2 No 1 Yes 2 L 9 Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown ACUTE RENAL FAILURE Division of Vital Records, Certificate: To Be Completed DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy s certificate has b lirector, page 2 s Yes 2 No 2 X No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral of 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours after c To the Funeral Direct completed filled in by 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my apicing Medical 29a. Certifier 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie mella m. 2010 January of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date fited (Mointh; Day, Year)

MEH 32. Registral Signature 11 USLER DRIVE TUWOUN.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6.15 AM Robin Donaldson Coblentz Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner or Location of Death 4c. County of Death GILCHUST OSDICE altimere attmere If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months (Month, Day, Year) 1 23 1931 New York Hours Director 120-26-7205 78 Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Yes 2 No Marvland N/A Baltimore P 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 201 Edgevale Road 21210 U.S.A. "natural", or items 11. Marital Status . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 X Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Teacher/Administrator Education 5+ years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Henry Louis Donaldson Margaret Fellows 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Cristin Fair (daughter) 7500 Hancock Avenue Takoma Park, Maryland 20912 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Green Mount Crematory Jan 4,2010 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home,
6500 York Road Baltimore, Maryl Joseph Maryland 23a. Part 1. EMEr the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ bar Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): and -transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months? Month Pregnant at time of death signed by the aid P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autonsy certificate 2 🗆 No 1 Yes 25. Was case referred to medical director, æ 26. Place of Death (Check only one) examiner? Other: ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Sther (Specify) After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendli within 24 hours after death. To the Funeral Director; Af 1 Yes 2 No Accident Investigation 6 Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 68286 an 2 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) charles st MD 21204 Ne 8. 701. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 4 2010 Registrar

DHMH 17 Rev 7/2009

Box 68760

of Vital

Division

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	0.		Decedent's Name (First, Middle	, Last)				2. Date of Death Month Da	av Year	3. Time of Death
	Physicia		Edith	France		Dykes		January 3	2010	11:45 p M
>	/Medic Examin		4a. Fecility Name (If not institution,	, give street and number)		4b. City, Town, or Lo	cation of Death	4	c. County of Dea	th
			Golden Living	g Center		Westmi			Carr	o11
	Funeral		5. Social Security Number	6. Sex 7. Age (In yrs.			f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year	) Co	thplace (State or Foreign ountry)
	Director		217-36-3459	93	Yrs.			Feb 24, 19	16   Vi	rginia
	A A		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation				10d. Inside City Limits
	sho	ō		1 4 4		Towson				1 ☐ Yes 2 ♣ No
,	28a-1	Director	MD Bal	ltimore		10f. Zip Code		10g. C	itizen of What Co	ountry?
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	within /2 hours affer death with fine maryland ene. Than "natural", or items 23e or 28a-f show re Medicul Evar in er mast ke molified al	by Funeral	11. Marital Status	12. Was Decedent Ever in L	J.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,		pecify Yes or No-	14. Race - Ame	erican Indian,
0	riter	F	1 Never Married 2 Marri	Armed Forces? ied 1 ☐ Yes 2 🕱 No	1			Rican, etc.)	Black, Whi	te, etc.
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21	Man "	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)				
2	Hiled Wi Hygien other th	Son	12			Housewife			•	me
nd	d oth	Be	17. Father's Name (First, Middle, I	Last)		18	8. Mother's Nam	e (First, Middle, Maide		
<u>  Xa</u>	should nd Men marke	은	Wilbert Fr						inders	7. 0. 1.
Maryland	2 sh and is m		19a. Informant's Name/Relationsh					ral Route Number, City		_
6	and fealth m 27 her t		Larry J. Franc			Deer Park osition (Name of		inksburg, I	D 2104 Location - City or	
Baltimore,	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. I be served other than "natural", or items 23e or 28a-f show any injury or other treumatic event, the Medical Examination and injury or other treumatic event, the Medical Examination in the Incities at Once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from State	cemetery, cre	matory or other place)				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 PState of Maryland Department of Health and Mental Hygiene Barth Doroshuk 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month 1920 hrs Medical Examiner Barth William Doroshuk January 1, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4811 Newport Avenue Bethesda Montgomery 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Foreign Maryland Country) Days Min. Months Hours 048-52-9224 Director September 19,1955 1 X M 54 2 F Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once, 1 Yes 2 X No Maryland Montgomery Bethesda Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Modical Examiner must be notified at once. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20816 United States 4811 Newport Avenue Funeral 11. Marital Status 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 X Married X Yes White 1 Yes 2 X No specify. 3 Widowed 4 Divorced If Yes, Give Year Specify unk δ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Business Owner Deaf Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nancy Mitchell John Doroshuk, Jr. 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4811 Newport Avenue, Bethesda, Maryland 20816 Catherine A. Picken / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) January 1 X Burial 2 Cremation 3 Removal from State Department o Important: injury or oth 11, 2010 New North Cemetery Woodbury, Connecticut 4 Donation 5 Other Specify 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service Licensee M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Pant I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician fallure. List only one cause on each line. Between Onset and /Modiesi a. Intraoral Gunshot Wound Death Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that imitiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical UNPENDED AMENDED ending physician use as the burial -Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the After this certificate has been signed by the attending inneral director, page 2 should be detached for use as t Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 Yes Yes 2 V No 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26 Place of Death (Check only one) funeral director, Be examiner? Hospital: 1 Inpatient 2 Other<sub>4</sub> Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 DOA 1 V Yes 2 No 28a. Date of Injury (Month, Day,Year) FOUND: 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Subject shot self Natural FOUND: neral Director: A Pending 1 Yes 2 ✔ No Jan 1, 2010 1915 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City 3 V Suicide 6 Could not be or Town, State) 4811 Newport Avenue, Bethesda, MD 24 hours a determined (Specify) Single Family Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the

OCMF 2006

30. Name and address of person ho completed cause of death (Item 23a) Jack Titus MD Deputy Chief Medical Examiner

29b. Signature and title of certifie

31. Date filed (Month, Day Year)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

State Registrar

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

January 2, 2010

acks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 **Physician** Jr. Frank Paul Di Marco 10:40 am January 1, /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford 709 West Baker Avenue Abingdon If Under 1 Year | If Under 8. Date of Birth (Month, Day, Year)
Sept.19,1948 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1**№** M 2□ F Months Days Hours Min. Yrs. 215-52-3745 61 Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Evaminer must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Abingdon Harford 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 709 West Baker Avenue 21009 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1X Yes 2 No US Army 1 Never Married 2 ☐ Married If Yes, Give 1969-75 Baltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2X No Specify þ 3 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacture permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other th any highry or other traumatic event, that once. Painter 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Wojciechowski Frank Paul Di Marco ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 709 West Baker Avenue, Abingdon, MD 21009 Barbara Anne Biedrzycki /Caregiver 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State Final Journey Crem. 1/4/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup>
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licente Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SLIDBLASTOMA months MULTIFORME **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Line to fair go a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐ No. 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 1 □Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical Wirs e Practition and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier R097025 WO CRNF son who completed cause of death (Item 23a) (Type, Print) 2 FERRIGNO CRB 2-1M-16, BALTO, MD Z1231 1550 ORLEANS ST

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Dorothy Catherine Eckels 9:00 2010 January 4, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Baltimore 5709 Carrington Drive White Marsh If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 2, 1928 5. Social Security Number 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2√2 F 81 220-20-9105 Yrs Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 21X No Baltimore White Marsh 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21162 14. Race - American Indian.

white

Approximate Interval Between Onset and Death

7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, It ≤ for all trainer must be notified at Director 5709 Carrington Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Black, White, etc filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed by Specify: 3 □Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Church Home and Elementary/Secondary (0-12) College (1-4or 5+) Medical Librarian Hospital 12 Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be and Mental Lillian Katherine Burton William Crockitt ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1213 Grafton Shop Road-Bel Air, Maryland 21014 Pages 1 and 2 Health a Stephen Eckels-son other 1 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ᇴ 1 ➡Burial 2 ☐ Cremation 3 ☐ Removal from State ō Garrison Forest Veterans Cemetery Baltimore, Maryland artment ortant: I injury o 4 Donation 5 □ Other (Specify) Jan. 22010 permit.
De artn
Importa
any inju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel And Cremation Services 3 Newport Drive-Forest Hill, Maryland 21050 endrae 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner ofo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760; Physician/Medical ası the attending power than the attention to the attention t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A

2 Row

32. Registrar's Signature

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 **☑**₩o 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending Injury 1 □Yes 2 □ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

State Registrar

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within 24 hours a To the Hospital

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1 - State Registrar

10a. State

MD

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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223 E. Mos boll no 21221

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 3:00 PM January Charles F. Elliott Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** <u>Rockville</u> <u>Montgomery</u> Andrus House 8. Date of Birth
(Month, Day, Year)
May 17, 1931 9. Birthplace (State or Foreign Country) Massachusetts 7. Age (In yrs. last birthday) Year If Under 24 Hrs. **Funeral** Months Hours 1 🛛 M 2 🗆 F **Director** 001-24-3008 May Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director 1 Yes 2X No Maryland Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20814 United States 7200 Exeter Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates. 1953–1956 Specify: 3 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) George Washington University 5+ University Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Yandell Elliott Barbara Pinkerton Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 Exeter Road, Bethesda, Maryland 20814 Margery K. Elliott / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State January 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 2010 . Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Exami ending physician and use as the burial-transit Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_\_ in the past 12 months? jo Month Day Year 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No cate has I 1 Yes 2 No director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) Asst. Living 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred X Natural (Month, Day, Year) 5 Pending ours after death.

neral Director; Af
filled in by the fu 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

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JAN 05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vinu Ganti, M.D. 19529 Doctors Drive,

DHMH 17 Rev 7/2009

Registrar

32. Registrar's Signature

D41162

Germantown, Maryland 20874

January 4, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Johnyel Faw	1-For State	ate of Maryland	/ Departmo			Mental		Reg. No. 20	10 00021
Physician Medical Examine	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year							3. Time of Death 1908 hrs	
	4a. Facility Name (if not institution 4117 Massachusetts	on, give street and number			City, Town, or L Baltimore	ocation of De		4c. County of NA	Death
Funeral Director	5. Social Security Number		ge (In yrs. last birt		If Under 1 Year Months Days	If Under 24	Min	Birth(MM/DD/YYYY)	Birthplace (State or Foreign
	214-98-6092 Usual Residence of Decedent	1 X X 2 F	31	Yrs.			6-21	-/8	Country) MD
Maryland 28a-f show any <u>d at once.</u>	10a. State 10b. County NA		10c. City, Town Balti						10d. Inside City Limits 1 X Yes 2 No
vith the Maryland s 23a or 28a-f show Enotified at once.	10e. Street and Number 4117 Massac	husetts Av	venue	1	Of. Zip Code	)		10g. Citizen of What	t Country?
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rs after de	3 Widowed 4 Div	orced If Yes, Give Year or Dates:	No No		es 2 X No		of work done		merican
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene.  Tant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Filmeral Director	Elementary/Secondary (0-12) 12th Grade		5+)	during most	of working life. [	OO NOT use	retired)	Sams C	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygene. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Commit		, Last)		OLK I		3.Mother's Na	ame (First, Middle	Maiden Surname)	
2121: should be fil and Mental I is marked atic event,	19a. Informant's Name/Relations	ship (Type, Print)	711				or Rural Route No		State, Zip Code) 21229
re, MI 1 and 2 s F Health a f fitem 27	Dieann Faw- 20a. Method of Disposition 1 X Burial 2 Cremation		20b. Place o	117 M of Disposition ory or other	lassach n (Name of ceme place)			ue Balti 20c. Location - C	
	4 Donation 5 Other Sp. 21. Signature of Funeral Service	pecify:	New C	athed:	place) TK Cent ral Cem. e and Address c	. 101	1-07-10 -8-2010	Baltin	nore, MD
Balti permit. Departi Import injury	23a. Part I. Enter the disease, or	complications that cause	d the death. Do no	638	N. Gil	mor	Street	<u>Baltimor</u>	
Wedical Examiner	failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.							Between Onset and Death
	Sequentially list conditions,	b. Due to (or as a cons							
ted nisit Examine	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	*							
execution and large lical fragility	UNPENDED	X AMENDED Ite	m#20h ne	rFH C	800 1/8	/2010	LIC SIJ		
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Box 6876( e death certificate the attending phy ed for use as the b	1 Yes 2 No 9 Uni	4 Pregnant a	t time of 5	Other	(Specify)				
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Division of Vital Records, P.O. tal or attending Physician: The law requires that the ra after death al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by P							24a. Was	psy pric	re autopsy findings available or to completion of cause of ath?
Vital Rec hysician: The l this certificate I director, page	25 Was case referred to medica		<u></u>			f Death (Che	1 Yes	2 ✔ No 1	Yes 2 No
f Vita Physicia er this ce and direc	1 Yes 2 No	Hospital: 1 Inpati		tpatient 3			rsing Home 5	Residence 6 🗸	Other: Scene
ivision of \ or Attending Phy after death Director: After tl I in by the funeral	1 Natural 5 Pend 2 Accident Inves	found for the fo	FOU 1900	ND: hrs	1 Ye	s 2 🗸 No	subject har	nged self	
Division o Hospital or Attending 24 hours after death Funeral Director: Aftered filled in by the fune rely filled in by the fune rel Certification:	3 Suicide 6 Coul 4 Homicide	d not be	njury - At home, fa wnhouse / Ro		actory, office bui	Iding, etc.	or Town,		or Rural Route Number, City e, MD
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn Medical Certification: To Be Completed by Physician/Med		hysician: To the best of n miner:On the basis of exa and manner stated	amination and/or in	th occurred evestigation,	at the time, date	and place, a death occurre	and due to the cau	se(s) and manner as and place, and due	s stated. to the cause(s)
	29b. Signature and title of certifie	er ,	-	-	29c. License i			January 3, 20	(Month, Day, Year)
3	30. Name and address of person			. 444 5			MD 24224	1, 5, 2	
State	Pamela E. Southall, N 31. Date filed (Month, Day, Year)	32 Registra	lical Examiner ar's Signature		Penn Street,	Daitimore	, IVID 27207		
Registra	JAN 05	2010 Vergus	V B. H	barks					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Vear Month **Physician** 3 19 2010 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Howard Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 13,1927 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 1 ☑ M 2 □ F West Virginia Yrs 368-24-8673 82 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at once. 1 ☐ Yes 2 🕱 No by Funeral Director Columbia Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21044 U.S.A. 10101 Governer Warfield Parkway #148 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Mayes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrator College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Foutty Nellie Marie Fought ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Evelyn F. Foutty (Wife) 10101 Governor Warfield Parkway #148 Columbia, Maryland 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Atlantic Crematory 1-4-2010 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road 21. Signature of Funeral Service Licensee Inc. Columbia, Maryland 21045 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-cause on each line. Immediate Cause (Final Physician DIPATOR disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine nding physician and se as the burial-transi resulting in death) Last Due to (or as a consequence of) Box 68760. Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 3 Probably 4 ☐ Unknown stoca 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 21 1 □ Yes 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this Medical Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? Manner of Death 28d. Describe how injury occurred After Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 Yes nours after death.

neral Director: A 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifies 29d. Date signed (Month, Pay, Year) 6 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kim Lesley Goring, M.D. 10724 Little Patuxent Parkway Columbia, Maryland 21044 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00023 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Car1 Nathan Fox 01 2010 January 9:50 P. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Brightview Assisted Living Catonsville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours Min. 1 X M 2 1 Ohio Director 273-14-5251 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? Funeral items 23a 713 Hidden Bluff Circle 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc is marked other than "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify:White If Yes, Give Year or Dates. WWII 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner Operator Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward Fox Hazel Marie Frysinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 713 Hidden Bluff Circle; Catonsville, MD 21228 Edward J. Fox Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Competery, crematory or other place)
4 Donation 5 Other (Specify Entombment Loudon Park Mausoleum 1/6/2010 Baltimore, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke uneral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 MO1537 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ onsosti.e disease or condition resulting in death) mon the Medical Due to (or as a consequence of): Examiner Dronces Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): bunial attending physician for use as the burial Physician/Medical death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Month Day 1 Yes 2 No been signed by the s should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Tes 2 No 3 Probably 4 Lunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 N 2 🗌 No 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 04, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21210

Registrar

State

31. Date filed (Month, Day, Year)

3455

32. Registra's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 4c per doc 8899 1-5-10 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ANUARY Z 632P 2010 MARY Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** BALT IMORE SAMARITAN If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth . Age (In yrs. last birthday) 90 yrs. Funeral Aug. 29, 1919 Days Hours 1 □ M 2 💢 F 071-14-7557 New York Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD Baltimore Parkville 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 8800 Old Harford Road Apt. 107 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event than "matural", or in any injury or other traumatic event than "matural", or in any injury or other traumatic event than "matural", or in a second than a sec 1 Never Married 2 Married <u>Ş</u> Maryland 21215-0036 white 1 ☐ Yes 2 ☐XNo Specify: Specify. 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Se econday (0-12) College (1-4 or 5+) Navy Exchange Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Joseph Peter Tannario Ella O'Flaherty 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 9606 Trepid Road—Nottingham, Maryland 21236 19a. Informant's Name/Relationship (Type, Print) Theodore Glotzbach, Jr-son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State St. Mary's Cemetery Jan.7,2010 1 XBurial 2 Cremation 3 Removal from State Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Si, nature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death m diate Cause (Final Physician/ INFARCTION ACUTE MYOCARDIAL ise se or condition realting in death) Medical Examiner ATHEROSCLEP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) burial-transit and To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death s been signed by the sahould be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 page 2 s Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 XNo ဂ 1 🔲 Yes €R/Dutpatient 3 □ DOA 1 Inpatient Manner of Death 28a. Date of injury (Month, Day, Year) 8b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at Natural Accider iniury work?
1 Yes 2 No 5 Pending Accident Investigation completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier for and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated by knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination 3 Certifying Nurse Practioner: To the best 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number 2010 death (Item 23a) (Type, Print) mpleted cause o 30. Name and address of person KERITH 5601 LOCA BUD BALT, MORE MD 21239 JOSEPH 31. Date filed (Month, Day, Year) 32. **Registrar's Signature** State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January Physician/ Joseph Granofsky 2010 6:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore 1343 Weldon Ave 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) Social Security Number 217-18-3730 Sex **Funeral** 1**X**XM 2 □ F Months Days Hours Min. 7/25/1923 Mary land 86 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Baltimore MD Towson 1 🗌 Yes 2 🛣 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number Completed by Funeral 21212 USA 6451 Charles St 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) DO NOT use retired) Welder Elementary/Seconday (0-12) College (1-4 or 5+) Welding Be 18. Mother's Name (First, Middle, Maiden Surname)
Marie Hemerka 17. Father's Name (First, Middle, Last)
Lambert Granofsky ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Karen Kaminski / Daughter 1343 Weldon Ave. Baltimore, Maryland 21211 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/6/2010 Towson, Maryland Hilltop Serv. Corp 4 Donation 5 Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 21. Signature of Funeral Service Licensee Ruck Towson Funeral Home, Inc. 1050 York Road 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Priysician 4-CRS COMPLICATIONS OF Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has funeral director, page 2 s autopsy perform death? 2 No 1 🗌 Yes certificate Yes 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be dayshters Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA residence Director: After this d in by the funeral dir 27. Manner of Deal 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year) Natural Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after des **To the Funeral Directon** completed filled in by th 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29c. License number 29d. Date signed (Month, Day, Year) and title of certifier 29b. Signatuj anvar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ( Towsun (,701 31. Date filed (Month, Day, Year)
JAN 0 5 2010 62. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician Jovce M. Hamilton 2113 PM 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK KLINE HOSPICE HOUSE AIR If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 💢 F 217 28 2216 VOV 16 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County f show Item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Medical Exemple in unit to inclified at 1 XYes 2 ☐ No Director -REDERICK REDERICK mn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6007 USA DRIVE 21703 GREENFIELD Funeral 14. Race · American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify. ģ WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL NURSING 0 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F LINTHICUM MYERS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important: If Item 27 is ma any Injury or are 19a. Informant's Name/Relationship (Type. Print) FREDERICK MO21703 Husbano MIVE 6007 GREENFIELD James 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/5/2010 FREDERICK, MO RESTHAUEN CREIN 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility J V 2 UM BUT 60.28 SYKES VILLE RD ELDS

23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility JNZUMBUN 121+ a Mov Co. ELDERSBURG-MO 21784 Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner car Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iabetese Methlus Examine this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Year Month Day 5 Other (specify) 1 ∐Yes 2 KDNo 9 Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐Yes 2 🗷 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 ROther (Specify) HOSPICE 2 **X** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

 Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certifica within 24 hor To the Fune completely fi

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick, MD Boushmans

and manner stated.

31. Date filed (Mortin, Day, 32. Registrar's Signati 2010

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death JANAURY Day 9:45 A<sub>M</sub> Physician/ MARGARET HELEN HIEHLE Medical 4a. Facility Name (if not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Onio ( 1 □ M 2**XX** F 88 September 22, 1921 289-18-1711 Director Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits ural", or items 23a or 28a-f sho Examiner must be notified at death with the Maryland Director 1 Yes 2 No Baltimore Baltimore Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21212 6806 Bellona Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes XX No
If Yes, Give XXX Never Married 2 Married þ Maryland 21215-0036 72 hours after White 1 ☐ Yes 2XX No Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Religious Ministry Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F Theresa Spohr Herman Hiehle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 West Joppa Road Towson, Mary Jand 21204 permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 Is any injury or other trau Sister Loretta Cornell MHSH Guardian Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Jan 6, 2010 New Cathedral Cemetery |Baltimore, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ature of Funeral, Service 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician SEPTIC SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner URINARY TRACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami requires that the death certificate be executed BOWEL OBSTRUCTION and Due to (or as a consequence of): resulting in death) Last burial physician the burial Physician/Medical P.O. Box 68760 attending properties for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) the g 🔲 Unknown 9 Unknown is been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown ACUTE RENAL FAILURE Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has b After this certificate has funeral director, page 2 autopsy performed? Yes 24 No death? 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 XNo 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Suicide 1 🗌 Yes 2 🗍 No Investigation the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined 4 Homicide Medical 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DICKINSON.

32. Registrar's Signature

7621

29c. License number

D

67248

OSLER DRIVE.

29d. Date signed (Month, Day, Year)

TOWSON.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2 -Month Year ZD)D Physician/ Marcella Hensel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Burnje Sy Baltimore Washington Medical Center If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months 1 □ M 2 🖾 Hours Septh, Day Year 1925 Country) OH 217-22-9868 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f 1 🗌 Yes 2 🔀 No Anne Arundel Millersville Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a or must be n ö Funeral 8387 Brookwood Road 21108 items ? permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Medical Examiner Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò 1 Never Married 2 K Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates White "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) I Hygiene. the Assembler Fabrication 8 of Health and Mental Hygie If item 27 is marked other ir other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Curtis В. Hurst Grace Maxwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Gilbert D. Hensel (spouse) 8387 Brookwood Road, Millersville, MD 21108 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗵 Burial 2 🗌 Cremation 3 🗒 Removal from State Jan. ō Department of Important: If any injury or once. Glen Haven Cemetery 4 Donation 5 Other (Specify) 2010 Glen Burnie, Maryland 21. Signature Funeral Service Licenses 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or condications that careed shock, or heart failure. List only one cause on each line d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine cause (Disease or iinjury usine of: led by the attending physician and detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Marcell death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 
Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 Yes 2 No Year Day 5 Other (specify) Pregnant at time of death 1 Yes 2 1 9 Unknown cate has been signed by the page 2 should be detached Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? perform Yes 2 1 Tyes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗪 rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Aurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 8006 vio completed cause of death (Item 23a) (Type,

State Registrar 31. Date filed (Month, Day, Year)

180 A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Johnson **Physician** ZOID Robert Christopher Kerbold Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** G-) en Burni Baltimore Washington Medical Center If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 A M 2 □ F Date of Birth (Month, Day, **Funeral** Year) Months Days Hours Min. 140-14-4707 **Director** Sept. 16,1924Elizabeth CityN. Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 Is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Evaminar must be notified at 1 □Yes 2 No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 412 Ferndale Avenue 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 MYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □ Yes 2 No White Specify: Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Senior Chief Engineman U.S. Navy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Otto Herbold Della Schwenler ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr Robert C. Herbold Jr. /Son 241 Arundel Road Pasadena, MD 21122 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 14 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets. Cem. 7, 2010 Crownsville, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Delleno 11101479 Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Com Can **Physician** disease or condition resulting in death) /Medical Due to (or as a covequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Completed by Physician/Medical Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Box ( IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Day 5 ☐ Other (specify) been signed by the should be detached to 1 ☐Yes 2 ☐ No o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be irector, page 2 s autopsy performed 1 ☐ Yes 2 No Division of Vital 1 ☐ Yes : After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation \* Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 2 (Check only and manner stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address

f person who completed cause

32. Registra

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Jean De lores 3:12 AM Va January Johnson 2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) County of Death Examiner Lanham George Trince mount last birthday If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 69 Months Days -676 1 □ M 2 🗷 F Hours 578-56 Director rainia July 31, Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No **Funeral Director** annam Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 20706 Sinmount 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Blac 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Haynes & Daughter Maryland Sharon aurel 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 Removal from State Metropolitan Crematory Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee

Robert B Ball Funeral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caused or respiratory arrest, shock, or heart failure. List only one cause on each line. end Hrlington, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Danwea Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) be executed Division or Vital Records, P.O. Box 68760, 🌽 use as the burial-tra Due to (or as a consequence of): cate has been signed by the attending physician or page 2 should be detached for use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Únknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 62063

Registrar

State

ente

102

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14207

32. Regist r's Signature

Park

5.

enel

31. Date filed (Month, Day, JAN 0 4 20

Day (ear)

6-41

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010

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	-		Union Memorial F  5. Social Security Number 6		(In yrs. last	t hirthday)	Bal If Under 1	timore	der 24 Hrs.	8. Date of Birt	h	N/A	Diethol	ace (State or F	Fomine
	Funeral Director		203-44-7983	1 X M 2 □ F	55	Yrs.		ays Hour		8. Date of Bird (Month, Da Feb. 7	y, Year) 195	54 N	Countr	Jersey	-oreign
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	with s 23a ust b	Funeral	506 E. 41st. S	treet Apt.	1			21218				U.S.	Α.		
	death item		11. Marital Status	12. Was Decedent Ev		13. V	Vas Decedent Yes, specify	of Hispanic	Origin? (Sp	ecify Yes or No-		14. Race - Ai Black, W			
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Σ	of Health and Ment of Health and Ment fitem 27 is marked rother traumatic		Clara M. Craig	(mother)		6119	Twin S	ilo Dr	ive	Blue Be	11.	Pennsy.	1va	nia 194	+22
ore	ye 1 ar t of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	☐ Removal from State	cen	netery, crem	sition (Name of natory or other	place)	į	Date	20c. Lo	ocation - City	or Tov	/n, State	
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ğ.	he dea y the a	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	time of dec	201 5	TOTTE (apecin	y)							
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Division of Vital	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,		4 Homicide determine			e, farm, stre	et, factory, of	ice		28f. Location (S City or Tow			Rural F	loute Numb <b>e</b> r,	,
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	To the within To the comple	Σ	only one) 3 L. Certifying N 29b. Signature and title of certifier	urse Practioner: To the b	resiormy ki	iowieage, d		ense numbe				te signed (Mo			
	7 - 0		· and	mo			AT	242	8946	s- B1	1)-	2/10			
	1		30. Name and address of person wh	o completed cause of de	ath (Item 23	3a) (Type, Pi		با ا	7 7 7	. ,	-	1		. 15	
)	, ∨		Amy Abdallah	Union Me	mort	al Ho	spital.	201 E	E. Uni	versity	Pay	KINGY	Ba	Stomar	4, MO
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	ha d	. 1			J		1			,

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9:00 PM 2010 Jan Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner bathmore altimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Davs 1 □ M 2 🛛 F Months Hours Min. 0371471918 Country) **GERMANY** 220-07-0418 Director Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State within 72 hours after death with the Maryland Director 1 Yes 2 X No BROWARD TAMARAC 10f Zin Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 33321 9200 LIME BAY BLVD., 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian "natural", or iter edical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced WHITE Completed permit. Page 1 and 2 should be filled within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natuu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) FURNITURE & BATH SHOP OWNER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LOWENTHAL SELMA JULICH 0TT0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLEN UHLFELDER / DAUGHTER 3418 MANOR HILL ROAD, BALTIMORE, MD 21208 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State CHEVRA AHAVAS CHESED 101/03/2010 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signati re of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD. 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oriset and Deathy Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) igned by the a be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown the Hospital or Attending Physician; The law requires 1 🗆 Yes cate has been sig page 2 should b 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 12 No Other: 4 Nursing Home 5 Residence ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 68286 anuam 2,2010

Registrar

State

6701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

West

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31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician Medical Physician (Medical Physician Medical Physician Medical Physician Medical Physician Medical Physician Physician (Medical Physician Physicia				1 - For State Registrar	State of Ma	ırylanı		epartme <i>Certifica</i>			nd Mental	Hygier Reg. N	71111	00033	3
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213-3-4-7600 William Residence of December 100 Sign sensor Incompany 1		Funeral		5. Social Security Number () 6. Se	x 7. Age	e (In yrs. la	ast birth	day) If Und	er 1 Year	If Under 24	Hrs. 8. Date	of Birth		hplace (State or Foreign	)
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Section of the control of the cont		er de; items ner.m	nne		Armed Forces?		5.	13. Was Dec If Yes, sp	edent of H ecify Cuba	ispanic Origi an, Mexican, I	n? (Specify Yes Puerto Rican, et	or No- c.)			
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Physician Modifical Examiner    20	סר	of of		1 🔀 Burial 2 🗆 Cremation 3 🗆 F		20b. Pl	lace of L emetery,	Disposition (No crematory or	ame of other plac	e)			•		
Physician Modifical Examiner    20		artmer prtant Injury				Hol	<u>ly F</u>	22 Name	and Addres	ss of Facility				-	L
Physician Medical Examiner  Physician Medical Examiner  The part of the part o	Ba	Pen Pen any any		Packad C	5-11	0 3	50.	Bruzo	zinsl	çi Func	eral Hon	ne PA	ex. Marv	land 21221	
Physician Medical Examiners of death   Sequential in death   Seque				23a. Part 1. Enter the disease, or complishock, or heart failure. List only of	l' tion de caused	the death	. Do no	ot enter the mo	ode of dyin	g, such as ca	ardiac or respira	tory arrest,		Approximate Interval Between	
Due to for as a glossequence of):    Section   Column   C				Immediate Cause (Final disease or condition	Chronic		str	uctiv	e Pi	elmon	any -	Disea	use.	Onset and Death	
Due to for as a glossequence of):    Section   Column   C				resulting in death)	Due to (or as a	a consequ	ience of	):	/	- \					
The content of the			e	Sequentially list conditions, if any, leading to immediate	b. Due to for as ε				tens	ive					_
See   10   10   10   10   10   10   10	V	outed id ansit	mim	cause. Enter Underlying Cause (Disease or injury that initiated events	Sepsi	2,									
The state of the s	, ,	e exercian ar urial-tr		resulting in death) Last	()			):							
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manne_cof Death 1	876	physic the b	dica	•	d. Ineu	mar	119								_
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25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manne_cof Death 1	E E	ne lav e has ige 2 :	dmc						-	***************************************		autopsy performed?	prior to death?	completion of cause of	
Yes   2   No   1   Yes   2   No   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes   2   No   28c. Injury at   28c				25. Was case referred to medical						26. Place o			No 1 LYes	الليا 2 عالم	_
296. Signature and title of certifier  296. License number  RESOCO  1-1-2010  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  HIEX is Davis HD 9000 Frankun Square Drive Balthmore MD 21237  State  31. Date filed (Month, Day, Year)  33. Registrar's Signature	>	nysici his ce I direc			Hospital: 1 Inpatie	nt 2 🔲	ER/Outp	oatient 3 🗆 [	OCA Oth	er: 4 🗌 Nurs	sing Home 5	Residence	6 ☐Other (Spe	cify)	
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296. Signature and title of certifier  296. License number  RESOCO  1-1-2010  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  HIEX is Davis HD 9000 Frankun Square Drive Balthmore MD 21237  State  31. Date filed (Month, Day, Year)  33. Registrar's Signature	1	l hours unera siy fille													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  HIEX IS Davis HD 9000 Franklin Square Drive Balhmore MD 2123.7  State  31. Date filed (Month, Day, Year)  33. Registrar's Signature	7	the F the F mplet	Medi	one)											_
State	15	0 0 K		230. Signature and title of certifier	4						000				
State				30. Name and address of person who c	ompleted cause of de	eath (Item	23a) (T	ype, Print)	14	5 0		/	7- 0	2070	_
State		9		Alexis Davis H	D 900C	FR	ank	CLIN S	quan	e Dr	rive Bo	e l'Ama	ne MD	21237	
AGUISTIGHT I A N. I.I.A. A. SARAH A.		Sta Registr		31. Date filed (Month, Day, Year)	3. Registra	ar's Signat	ure	la del					/		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day Year John Lewis Kotch 9:05 PM 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. Riverview Nursing Home Essex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 ☑ M 2 □ F Months Days Hours Min. (Month, Day, Year) 218-10-9752 93 1916 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Ves 2 No Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Franklin Ave. Apt. 601 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White 3XXWidowed 4 □ Divorced WWII Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Building Inspector Baltimore City 10 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence Lewis John Kotch (Brother)<sub>19b. Mailing</sub> Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) h 6400 Hartwait Street Baltimore, Maryland 21224 19a. Informant's Name/Relationship (Type, Print) Mr. James William Kotch 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State emetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 1/7/2010 4 Donation 5 Baltimore, Maryland ak Lawn Cemetery Other (Specify Signature of 5 <sup>22</sup> Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland Ave. 23a. Part 1. Inter the disease, or complications that caus shock or heart failure. List only one cause on each limit of the cause of th ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final uncer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for sels consequence of, Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of):

Physician/ Medical Examiner

Exami

Completed by Physician/Medical

Certificate: To Be

Medical

29b. Signature and title of certifier

Physician/

Medical

**Examiner** 

**Funeral** 

Director

28a-f shov

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23a

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"natural",

traumatic event, the Medical

injury or c

and Mental Hygiene.

permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is

72 hours after

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Funeral

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Completed

Be

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MD

Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran attending physician for use as the buria as page 2 s certificate funeral n 24 hours after death.

e Funeral Director: Afteleted filled in by the fun

Division of Vital Records, P.O. Box 68760

23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No  23c. If yes, outcome of pregnancy  1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)								
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 □ Probably 4 Unknown							
		24a. Was an autopsy performed?  1  Yes 2 No							
25. Was case referred to medical examiner?	26. Place of Death (Check or	nly one)							
1 Yes 2 No	Hospital: 1  Inpatient 2  ER/Outpatient 3  DOA Other: 4 Nursing Home	5 Residence 6 Other (Specify)							
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigat	28a. Date of injury (Month, Day, Year) 28b. Time of injury work? 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred							
3 Suicide 6 Could no 4 Homicide determine		Bf. Location (Street and Number or Rural Route Number, City or Town, State)							
(Check 2 L Medical Exa	nysician: To the best of my knowledge, death occured at the time, date and place, and d miner: On the basis of examination and/or investigation, in my opinion, death occurred at the urse Practioner: To the best of my knowledge, death occurred at the time, date and place, a	e time, date and place, and due to the cause(s) and manner stated							

29c. License number

D61907

Ave, Bultimore

29d. Date signed (Month, Day, Year)

MD 21221

State Registrar

DHMH 17 Rev 7/2009

completed

within 2 To the F

(Item 23a) (Type, Print)

4 Mace

MD

32. Registrar's

ss of person who completed cause

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2. Date of Death

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#29d perDVR, 8899 1/4/2010 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Debra **Physician** Ann Land 2010 Jan. 10:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 8 Woodmans Court Essex Baltimore Co. 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6 Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, **Funeral** 8. Date of Birth (Month, Day, Year) Months Days 1 □ M 2 🖾 F Director 218-68-8914 54 18. 1955 Maryland Usual Residence of Decedent 10a. State 10h. County 10c. City. Town or Location show 10d. Inside City Limits other traumatic event, the Medical Examinating be notified at Director 1 ☐ Yes 2 K No MD 28a-f Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or items 23a 8 Woodmans Ct. 21221 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 TM Married more, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 ☐ No Specify. ğ Specify: 3 Widowed 4 Divorced Year or Dates: natura!" White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Reserve Elementary/Secondary (0-12) College (1-4or 5+) Bank 12 Years Cash Cerifier marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Albert E. Blachowicz Dolores A. Rotunno and 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Thomas L. Land (Husband) 8 Woodmans Ct. item 27 Essex, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important; If it any Injury or o ₹ 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 1/6/2010 Middle River, MD 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Livens intron 7922 Wise Ave. Dundalk, Maryland or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. List only one cause on each line. Immediate Cause (Final 11 ARIAN **Physician** par resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Jer Directo for en a nonsecuenna offi Exami and the burial-trai Due to (or as a consequence of) Box 68760, attending physician death certificate be Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Year Day 5 Other (specify) □Yes 2□No P.O. the detached 9 Unknown 9 Unknown s been signed by t should be detach The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of Injury (Month, Day, Year) ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t oletely filled in by the funera 28b. Time of 28c. Injury at Work? After 1 Certification: 28d. Describe how injury occurred Division 1 Natural 2 □ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) within 2 the 29b. Signature od title of certi 29c. License number 29d. Date signed (Mo20 PG, Year) completed cause of death (Item 23a) (Type, Print) Name and a N. Charles ST BATMEN, m 21204 32. Registrar's Signature Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

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DHMH 17 Rev 1/2001

Registra

JAN 0 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item7 per fh g899 1-8-10 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death January 4Day **Physician** Madeline Blanche Menin 2010 8:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death **Examiner** Brightview Assisted Living Baltimore Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, ) Sept. 27, **Funeral** 1 □ M 2 X F Months Days Hours Min 219-05-4855 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at MDBaltimore Glen Arm 1 ☐ Yes 2 X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11505 Manor Road 21057 U-S-A-Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2∑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify. Specify: White 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than At Hame Elementary/Secondary (0-12) College (1-4or 5+) Home maker Pages 1 and 2 should be filed annent of Health and Mental Hygiant: If Item 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Precht Susan Preitt ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Heath ar
Important: if item 27 Is
any injury or other trau 11505 Manor Road, Glen Arm, MD 21057 Eugene Menin/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
More Land Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 01,07/2010 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) Park 22. Name and Address of Facility Exams Funeral Chapel & Cremation Services 8 800 Harford Rd. Farwille, MD 21234 21. Signature of Funeral Service License rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death liate Cause (Final mm late Cause (Fi dis se or condition ulting in death) **Physician** DIROLD /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Electronscript of Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 ∐Yes 2 🔀 No ours after death.

eral Director: After this certifical filled in by the funeral director, in the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Hospital: Other: 4 Nursing Home 5 Residence 6 XOther (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Living 28b. Time of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of repritified 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rahnama, M.D. -9512 Harford Road, Suite 4, Baltimore, Maryland 21234 Dr. M.R. 31. Date filed (Month, Day, 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

JAN 05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. Gounty of Death **Examiner** Annapolis Medical mi If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral 1 ☐ M 2 🖾 F Days Min. Months Hours May 20, 1941 Huntinton NY 089-34-1169 68 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important if fleath and Mental Hyglene. Important if item 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10c City Town or Location 10d. Inside City Limits 10a, State Director 1 🗌 Yes 2 🔯 No MD Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 773 Barger Drive 21032 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 🗆 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Beautician Beautician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ George Hunter Merritt Minnie Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr Francis J. Murphy/Husband 773 Barger Drive Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State January 1 X Burial 2 Cremation 3 Removal from State Huntington Rural Cem. 8, 2010 Huntington, NY 4 Donation 5 Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Signature of Funeral Service Licensee Services PA 1 2ND SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition piroution Medical resulting in death) Due to (o as a consequence of): Examiner manaru Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? 2 No certificate Yes 2 Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) director, Be examiner? Hospital Other: 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မြ this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 5 Pending injury 1 Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2680 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 2001 Medical aclanna raynham 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January I, 2010 2010 Mossburg 11:51 A M Edna Mae Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🎇 i Year922 April 20, 579-20-5161 Director Virginia Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or orher traumatic event, the Me \*al Examiner must be notified at any injuy or other traumatic event, the Me \*al Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Bethesda 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5510 Southwick Street 20817 United States 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married If Yes Give 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carrie Virginia Johnson Charles Euclid Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
230 Wyngate Drive, Frederick, Maryland 21701 19a. Informant's Name/Relationship (Type, Print) James Alton Mossburg / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) January Rockville, Maryland Parklawn Memorial Park 2010 Signature of Funcial Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Inc. M01305 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final 1 Hour Death Physician/ Acute Myocardial Infarction Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy þ in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year signed by the a 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension, Renal Failure, Dementia 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 s autopsy performed? Yes 2 X N 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 2 X No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) nours after death.

neral Director: After the funeral of the funeral filled in by the funeral filled in the funeral fille 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural 1 Yes 2 🗌 No Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npleted (Check 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

29b. Signature and title of certi

Joel E. Buzy, MD.

31. Date filed (Month, Day, Year)

JANUD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

arks

D64235

9901 Medical Center Drive, Rockville, Maryland 20850

29d. Date signed (Month, Day, Year)

January 1, 2010

**Funeral** 

Director

Department of Heal Important: If item 2 any injury or other once.

Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 2010ar 2, 1:45 A M January Martin Norma Willetta /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Montgomery Hospice-Casey House If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🛛 F Virginia December 7, 1925 235-36-6066 84 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 □ No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 318 West Edmonston Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🕅 No Specify: ģ Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Direct Mail Receptionist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Enid Marguerite Vanscoy ဥ Ernest Engle Mull 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Swann / Daughter 4904 Baffin Bay Lane, Rockville, Maryland 20853 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition January 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Parklawn Memorial Park 2010 Rockville, Maryland Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service Licensee · M01360 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2**X** No 2 No 1 ☐ Yes 1 Yes 26. Place of Death (Check only one) Other:  ${}_{4} \square$  Nursing Home  ${}_{5} \square$  Residence  ${}_{6} X \square$ Other (Specify)  $\underbrace{Hospice}$ 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d, Date signed (Month, Day, Year) January 3, 2010 6001 Muncaster Mill Rd., Rockville, Maryland 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 3, 2010 2:45 <u>Emma P.D. Mullineaux</u> January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Family Care Assisted Living Marriottsville Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 💢 F 1922 Director 87 May 13, 217-16-5705 <u>Maryland</u> Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, I'm Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo MD Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9414 Dawnvale Road 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 2 3 ₩ Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Otto Hartman Florence K. Trageser P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any injury or other traun once. 9414 Dawnvale Road; Baltimore, MD 21236 Dale Mullineaux 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 1/5/10 Towson, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** DEGENERATIVE disease or condition resulting in death) SENILLE BRANN DISORDER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any lizability immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🗷 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4 Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate rmeuz 2∭No 2X1No 1 ☐ Yes 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( (Specify) \) HOSPICE Hospital: 1 Yes 2X No 1 🗌 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred 1 Natural 5 Pending Injury neral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 050404 (PUYISICAN 04 2010

Registrar DHMH 17 Rev 1/2001

State

SUITE

COUMBIA

21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALKER PERSON PRINTED PKW

32. Registrar's Signature

PATULENT

LITTLE

Year

5

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January Marudas Lula 2010 9:00 am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A Baltimore Genesis Long Green Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year 19<u>16</u> Days 1 🗆 M 2 🗶 F Months Hours Sept 26 New York **Director** 384-14-5619 93 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 X Yes 2 No N/A Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 USA 9 Wendover Rd. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 of Health and Mental Hygiene, item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Panayioth Kyvelos Nicholas Leventis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Lake Ave. Baltimore, Md. 21212 Mr. Peter Marudas/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of I Important: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Detroit, Michigan 1-7-10 Woodlawn Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility
Ruck Towson
1050 York Rd Funeral Home, Towson. 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final CARDIOVASCULAR DISEASE Physician/ ATHENOSCIENOTIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death 2 **1** No 9 Unknown g Unknown Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PARKINSON'S DISEASE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page this certificate 2 No Yes 2 No 1 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖳 No 1 🗌 Yes 욘 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 29c. License number D31136

Registrar
DHMH 17 Rev 7/2009

State

9005 KILBRIDE RD, BALTIMONE, UND 21236

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 1 2010 Physician 6:00p Ouinnie Mathis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carrol1 Lorien Nursing H**o**me Mt. Airy If Under 1 Year | If Under 24 Hrs. B. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Min. Hours Months 213-64-1249 1 ☐ M 2 M F Tenn. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 28a-f show injury or other traumatic event, the Medical Examiner hust be putified at MD West Friendship Howard 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 may injury or other traumatic event, the Widtest Exan Lord Lord Deco. 21794 USA 12396 Frederick Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No If Yes, Give Year or Dates: Specify: Completed by White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lee Mathis Cordie Green ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kevin Mathis (Son) 12396 Frederick Rd. West Friendship, Md. 21794. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Liberty Baptist 01/05/2010 Lisbon.Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville.Md. 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) archon 0100131 **Physician** Days /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 1 Tes 3 Probably 4 Unknown Was a. autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Mannet of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide hours after within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10059943 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

John ( Aprel

31. Date filed (Month, Day,

295

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Pearl R. Maynard 2010 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Woodlands Assisted Living Middle River Baltimore If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, an. 8, 1 □ M 2**X**□ F Rhode Director 037-18-9132 85 J<u>an.</u> 192 Island Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Dundalk Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 United States 2903 West Woodwell Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2XX No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√ No Specify: Completed 3 Widowed 4 □ Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Years <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Ethel R. Fink Stephen A. Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222 2903 West Woodwell Road Dundalk, Maryland Claudia Bruzdzinski (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 1/6/2010 Bel Air, Maryland Air Mem. Gdns. 4 Donation 5 other (Specify) 21. Signature of June 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk. Maryland 23a. Part 1. Effer the disease, or complications that cause if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Chroniz Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or se a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last ल्ल Division of Vital Records, P.O. Box 68760 ed by the a page

completed filled in by

Lecrificate: 10 be completed by Physician/Medic	d									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of delivery Month Day Year								
	Part II. Other significant conditions con	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown								
	Dubete Attorios	24a. Was an autopsy performed 1								
	25. Was case referred to medical examiner?	only one) e 5 ☐ Residence 6 ☐ Other (Specify)								
	27. Manner of Death  1. Natural 5 Pending 2. Accident Investigation	00 0 1 (1)	8d. Describe how injury occurred							
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Street and Number or Rural Route Number, City or Town, State)							
Medica	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
_	29b. Signature and title of certifier	29d. Date signed (Month, Day, Year)								

State Registrar

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ss of person who completed cause of death (Item 23a) (Type, Print) GIN Philacliphia Ph

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Terrance Michael Murphy 435A M January 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Harford Memorial Hospital Harve de Grace If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Months | Days | Hours | Min. | Sept. 27, 1954 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F 216-68-9441 55 Director MD Usual Residence of Decedent 28a-f show 10b. County "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Harford MD Harve de Grace 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 459 Majestic Prince Circle 21078 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give should be filed within 72 hours after 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Construction Be 18. Mother's Name (First, Middle, Maiden Surname)
Lelia E. Heying 17. Father's Name (First, Middle, Last) Joseph Michael Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane A. Harms / Sister 459 Majestic Prince Circle, Harve de Grace, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. 1/3/2010 Woodbine, MD Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services 21. Signature of Funeral Service Licens Maishall aude PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death End Stage Hepatic Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 9 Unknown Month Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 s autopsy performed' 1 Yes 2 No Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural After (Month, Day, Year) Natural
Accident
Suic 5 Pending work 1 🗆 Yes 2 🗆 No Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide determined completed filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 7 the only one and title of certifi 29b 29c. License number 29d. Date signed (Month, Day, Year) idum Stus HO0 54439 January 2, 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) 4B North Aurius #210 Bal Air, Mid 21014 incent A giminaro 00 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

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Barke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2010 Year **Physician** Lucille Nadine Norton January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Center Randallstown **Baltimore** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) 1 ☐ M 2 ☐ F 281-42-4526 Yrs 63 17 Director May 1946 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 28a-f shov MD Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 1597 Homeland Drive Unit 1E 21784 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black. White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐ Yes 2 √ No Specify: white 3 Widowed 4 1 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) education College (1-4or 5+) secretary is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lucille Guillerer Francis B. Henry ၀ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
D. partment of Health a Important: If item 27 is any injury or other trai Brian V. McFarland (executor) 920 Frederick Rd., Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 1-4-10 Sykesville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Haight Funeral Home & Chapel Paige Haight Stenbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician amyotropic ateval Sclevoss disease or condition resulting in death) /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician and the burial-transit be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.0. 1 ☐ Yes 2 No 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy perform 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 1- Natural 5 Pending investigation

Records, spital or Attendi nours after death. neral Director: A / filled in by the fu To the Hospital or within 24 hours at To the Funeral D

Division of Vital

Registrar

2 Accident

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who co

6 Could not be

determined

1 ☐ Yes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Month

Day

00047

11:00a M

Ohio

10d. Inside City Limits

Approximate Interval Between Onset and Death

Vegys

Year

1 ☐ Yes 2 🕅 No

Birthplace (State or Foreign Country)

D37573

2 No

2, 2010

cause of death (Item 23a) (Type, Print)

Reisterston

MD 21132

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month D TAN VARL Day Year Ohhor Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death County of Death Examiner Howan Rehab Health Ellicott City 7. Age (In vrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) New York Social Security Number If Under 1 Year 8. Date of Birth **Funeral** 1 M 2 F 052-22-0529 Januar 9 7, 1929 **Director** Usual Residence of Decedent or 28a-f show 10b. County 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2XX No Maryland Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21043 U.S.A. 5223 New Prospect Court 12. Was Decedent Ever in U.S. Armed Forces? 1 → Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 Divorced "natural" White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 shourd by man-Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Niagara Mohawk Land Surveyor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John O'Connor Mary Lunney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5223 New Prospect Court Ellicott City, Maryland 21043 Kate Gibson (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) St. Joseph's Cemetery 1-7-2010 Schenectady, New York 21. Signature of Funeral Service Licenses witzke funeral flowes, Inc. 5555 Twin Knolls Road Colmubia, Maryland 21045 23a. Part 1. Enter the disease, or shock, or heart failure. List of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, my one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) .xaminer quentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 9 I Inknown 9 Unknown ģ cate has been signed I page 2 should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 D Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed this certificate Yes 2 No 1 Yes Be 25. Was case referred to redical the funeral director, 26. Place of Death (Check only one) examiner? 2 1 No Hospital Other: 1 🗆 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Mann of Death Certificate: 28b. Time of 28c. Injury at s after death. Il Director: After t 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral D Medical Fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 29<del>d, Da</del>te signed (Month, Day, Year) 6th IM 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 300/ 1E 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year 300 PM **Physician** RAHDASS ERRANCE Talux who 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown HOSPITAL Baltimore North West If Under 1 Year | If Under 24 Hrs. | 8. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 054.78.0632 Months Days 1 M 2□ F 38 Director 08/19 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shov event, the Madical Examiner must be notified at Pikesville Baltimore 1 ☐ Yes 2 No MD Director Street and Number 10f. Zip Code 10g. Citizen of What Country? Omstead USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Thdian <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) Pizza Hut 1)rwer year 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Ramdass Bondram ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ramdass/Wife Marsha C.R Plesville, MD 21208 943 Olmstead Road : If item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, MD Important: I any Injury o once. Woodlawn Cemetery 07 10 Vaughy C. Greene Funeral SKS 22. Name and Address of Facility 21. Signature of Funeral Service License iberty Road Randall Stown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumoria disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. TYPS 2 NO 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 100 certificate 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 7 NO 1 ☐ Yes 1 Ampatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending 1 Natural at or Attendin s after death. I Director: Af 1 ☐ Yes 2 No investigation 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral E Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) D65843 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Old Court Road, Randallstown, HD Abdallah Kafroun 5401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 5 2010

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Robert Roeth Jr. January 01 2010 :10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 223 Altamont Avenue Catonsville Baltimore . Social Security Number 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 1 🛛 M 2 🗆 F Months Hours Min. Maryland 62 **Director** 217-50-0449 Sept. Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Baltimore Catonsville 9 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a Altamont 21228 USA Avenue items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 🖾 Yes 2 🗌 No Black, White, etc. 6 1 Never Married 2 Married þ and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates "natural", Specify: WhITE 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home Builder **Building** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be fi Department of Health and Mental Important: If Item Z7 is marked any finjury or other traumatic ev once. 2 Robert W. Roeth, Sr. Pauline Cross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Roeth Wife 223 Altamont Avenue; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Atlantic Crematory 1-5-2010 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signal Te of Funeral Service Licenses 630 Edmondson Avenue: Catonsville MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ALCEL WRIDARY STAGE disease or condition resulting in death) VEARS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to joi as a consequence on and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 1 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Dav Pregnant at time of death signed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗆 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Thrombosis RIGHT 24a. Was an 24b. Were autopsy findings available certificate has autopsy performe prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA မြ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending Natural iniury work? 1 🔲 Yes 2 🔲 No 5 Pending Accident Investigation pleted filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1 Lecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) ATTENDING 16200 2010 30. Name and addre s of person who completed cause of death (Item 23a) (Type, Print)

State Registrar NORBER TO M. MACHIEAR

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

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AMEND ITEM#29d, perDVR, G899, 1/4/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jahuary 1, 2010 MARIANNE KARLOWA RUPPERSBERGER 5:35P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Towson . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 213-22-3263 1 □ M 2**XX** F 82 Matter 13, 1927 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Baltimore 1 ☐ Yes XX No Maryland Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12310 Rosslare Ridge Road #207 21093 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces No 1 Never Married Married Completed by 1 Yes If Yes, Give Maryland 21215-0036 White 1 ☐ Yes 2XX No Specify: Specify: 3 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E ones. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Anna Marie Wolter Robert Krause Karlowa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12310 Rosslare Ridge Road #207 Timonium, Maryland 21093 William Leslie Ruppersberger Sr Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XX Burial 2 Cremation 3 Removal from State Druid Ridge Cemetery January 5,2010|Pikesville, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 11 Chell-Wie efeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease. Approximate Interval Between January Immediate Cause (Final Onset and Death Physician SOURMONS CELL CARCINOMA OF MOUTH disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause III Examine Due to (or as a consequence of) Cause (Disease or impury that initiated events resulting in death) Last igned by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Hospital or Attending Physician: Te law requires that the death Pregnant at time of death Unknown Month Dav Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by EMPHYSEMA Records, 1 Yes 2 No 3 Probably 4 Unknown ge 2 should 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 2 🗆 No certificale 1 🗌 Yes Yes the funeral director, p 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🖼 Ro Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: A 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 1 29b. Signature and title of certifi D64395 JANUARY 1, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 NOMARLES STI SUITE 4701 BALTIMORE, MB 21204 DANJEUE DOBERMAN, MD 31. Date filed (Month, Day, Year) 32. Regist ar's Signature State Registrar

uppersberger

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2010 Physician/ Month 3:45 RM January 4, Mary Stokes-Novak Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1 944 Days Hours Min. (Month, Day, Ye Feb 23, 1 DM 2 D 65 West Virginia Director 215-40-5899 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 United States 6521 Danville Avenue 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Yes 2 No. Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: 3 ₩idowed 4 Divorced White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event. The Maranones. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of MD Social Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Judson Greene Frances Jane Wilfong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul McElhiney /Son 15 Circle Drive York, PA 17407 20a. Method of Disposition 20b. Place of Disposition (Name of Date Jan 20c. Location - City or Town, State cemetery, crematory or other place) 05 1 Burial 2 remation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Beltsville, Maryland Chesapeake Crematory 22. Name and Address of Facility
Cremation and Funeral Alternatives Signature of Funeral Service Licenses 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Ester the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Due to (or as a construe of) **Examiner** Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy perform death? 2 🗆 No Yes 2 1 Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Matural Accident work?
1 Yes 2 No 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature at 29d. Date signed (Month, Day, Year) ٥ Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month  $5^{\text{Day}}_{\bullet} 2010^{\text{Y}}$ Swain January 5:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FutureCare Cherrywood Reisterstown Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sept 24, 1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Funeral 1 □ M 2 🕱 F Months Days Hours Maryland Director Sept **1**920 219-07-2214 89 Usual Residence of Decedent 23a or 28a-f show ist be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral and 2 should be filed within 72 hours after death with Health and Mental Hygline. Health are 18 marked other than "natural", or items 23 them 27 is marked other than "natural", or items 23 other traumatic event, the Medicial Examiner must! 21224 U.S.A. 8027 Gough Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give 1 ☐ Yes 2 🙀 No Specify. 3 X Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Unknown Johns Anna Carl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Dundalk, MD John F. Swain 8002 Delhaven Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State 4 Donation 5 Other (Specify) Carroll Cremation Ser 1/6/10 Hampstead, MD 21. Signature of Fuperal Service Licenses 22. Name and Address of Facility Eline Funeral Home ensens 11824 Reisterstown Rd. Reisterstown, MD 21136 2.3a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HIzheimeris disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year ed by the a detached f 1 Yes 2 kg 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Artery Disease Loronary 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed 2 1 No 1 Yes 2 No 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5  $\square$  Pending work within 24 hours after death. To the Funeral Director: Al 1 Yes 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the only one 3 L Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated D0023333 who completed cause of death (Item 23a) (Type, Print) Susteres Baltimore, Md 21709 2835

Registrar DHMH 17 Rev 7/2009

State

Saltimore, Maryland 21215-0036

Box 68760

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Division of Vital

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Amend #Please Type or Brint in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 20 Year 025 AM Ď Barbara W. Sugland /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale ranklin Square Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Num 042-56-3300 Funeral Days 1 □ M 2 ◯ F 49 Director 4-29-1960 Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or Items 23a or 28a-f sho event, toe Medical Evansians must be motified as Director 1 ☐ Yes 2 No Baltimore M Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12112 Sugar Mill Circle 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 Married Specify: African-American Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: 包 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Center for Applied Research Elementary/Secondary (0-12) College (1-4or 5+) Owner Technical Assistance 18. Mother's Name (First, Middle, Maiden Surname) <sup>17</sup>Louis Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental of Health and Menta f Item 27 is marked r other traumatic e <del>Lavis</del> Sigland Evelyn Wallace 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Russell/Husband 12112 Sigar Mill Circle, Middle River MD 21220 permit. Pages 1 and Department of Heali Important: If Item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Manorial Park 20a. Method of Disposition 20c. Location - City or Town, State 14 Burial 2 ☐ Cremation 3 ☐ Removal from State 1-11-2010 Arbutus, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Wile Fureral Home P.A. of Baltimore Co. 21. Şignature of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 Kindly 23a. Part 1. Enter the disease, or complications that cau and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final WITH MEDITIONS **Physician** brast innur disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to forms a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 PNo 2 1 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2. No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number OT 1,2010 1740820 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9103 Franklini Syvane Dr. W. Baltima Marylany 21237 OLIMONUMO MID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State parke Registrar

DHMH 17 Rev 1/2001

10-00015	
Carolyn Scott	

State of Maryland / Department of Health and Mental Hyo	giene 2010 0005							
	Reg. No.							
Physician/ 1. Decedent's Name (First, Middle,Last)	2. Date of Death 3. Time of Death							
ledical Examiner Carolyn Scott	January 1, 2010  Year  1620 hrs							
4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of Death							
Sinai Hospital Baltimore	NA  8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or							
Punelal	08-15-41 Foreign Country) SC							
Director  214-40-9470 1 M 2 X F 68  Usual Residence of Decedent	Country)							
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits							
₹     MD   Roltimore   Windsor Mill	1 Yes 2 No							
10e. Street and Number 10f. Zip Code 21244	10g. Citizen of What Country?							
MD Baltimore Windsor Mill  10e. Street and Number 36 Farmington Court 21244	USA							
11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? ( Spering Free Process)  14. Marital Status  15. Marital Status  16. Married  17. Meyer Married  18. Was Decedent of Hispanic Origin? ( Spering Free Process)  18. Was Decedent of Hispanic Origin? ( Spering Free Process)  19. Married  19. Marr								
1 Never Married 2 Married 1 Yes 2 No If Yes 2 No No specify:								
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of wo	Specify: American  ork done 16b. Kind of Business/Industry							
during most of working life. DO NOT use retired								
15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Education (Specify only highest grade completed)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)	Public School Sym							
18. Mother's Name (First, Middle, Last)	First, Middle, Maiden Surname)							
12th Grade 2yrs. Teacher Aid  17. Father's Name (First, Middle, Last)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)  19. Melson	Mae Nelson ral Route Number, City or Town, State, Zip Code 11.4							
The property of the property o								
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State							
The state of the place of the p	1-10 Owings Mills, MD							
The design of the part of the	lie Funeral Home F.A.							
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	reet Baltimore, MD 2121							
Physician  28a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause or each line.	Between Onset and							
Immediate Cause (Final disease a, End Stage Renal Disease or condition resulting in death)  Disease	Death							
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
S B B UNPENDED   AMENDED								
9 y y y y y y y y y y y y y y y y y y y	23d. Date of delivery							
Was decedent pregnant in the past 12 months?  Live birth  past 12 months?  Live birth  past 12 months?  The past 12 months?  Unknown  The past 12 months?  T	cy Month Day Year							
Other (Specify)								
	23e. Did tobacco use contribute to the cause of death?							
S, P.C.  In resigned to be determined by the det	1 Yes 2 No 3 Probably 4 Unknown							
Records, The law require; page 2 should be Completed	24a. Was an autopsy findings available prior to completion of cause of							
The la	performed?   death?   1 \sqrt{9} Yes 2  No   No   No   No   No   No   No   No							
25. Was case referred to medical examiner? Hospital: 1 Innatient 2 FR/Outpatient 3 DOA Other4 Nursing Innatient 3 DOA								
The late of Death (Check on Positial: 1 Inpatient 2 Fe/Outpatient 3 DOA Other Nursing: 27. Manner of Death (Manth Input) 28b. Time of Injury 28c. Injury at Work?	Home 5 Residence 6 Other:  8d. Describe how injury occurred							
E ≡ ₹₽ 0 1 V Natural E	od. Describe now rightly occurred							
No light to the first tendency of the first	8f. Location (Street and Number or Rural Route Number, City							
So be get of the second of the determined (Specify)	or Town, State)							
Solution of the first of the fi								
#	one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  and manner stated							
29b. Signature and title of certifier	29d. Date signed (Month, Day, Year)							
Mayone Inelstrile O.C.M.E.	January 2, 2010							
30. Name and attrices of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	1201							
State 31 Date filed (Month, Day, Year) 32. Registrar's Signature								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan 2010 7:00A M Stevens Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Hospital Baltimore NASocial Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🕅 M 2 □ F Months Days Hours Director 219-28-6453 77 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 USA 3918 Edmondson Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces 2 No
If Yes, Give Black, White, etcAfrican 1 Never Married 2 Married þ Dec: John St. Maryland 21215-0036 1 🗆 Yes 2 🖁 No Specify: Specify: American 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Amco Steel Company 10th Grade Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk. ပ္ Jennifer James Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $3918 \;\; Edmondson \;\; Avenue \;\; Baltimore, \;\; MD$ 21229 Jonnie M. Stevens-Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date King Mem. Pk. Cem 01-07-10 1 X Burial 2 Cremation 3 Removal from State Randallstown, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wylie Funeral Home P.A. 22. Name and Address of Facility 638 Gilmor Street Baltimore, Ν. MD 21217 fiblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, or co shock, or heart failure. List on Approximate Interval Between et and Death Immediate Cause (Final Physician/ Donatremia Lays disease or condition Medical resulting in death) Examiner olydipsea hogenic Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death s been signed by the s g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 2 🕱 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 🔲 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 29b. Signature and title of cer 29c. License number D51018 who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00057 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ MARGARET DALE SKIDMORE 7:30 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore County 31 Lambourne Road, #403 Towson If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sept 21, 1923 Pennsylvania 1 □ M 2 🔯 F Months Days Hours 86 Director 216-28-5787 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location at Director be notified 1 ☐ Yes 2 X No Maryland Baltimore County Towson 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21204 USA er than "natural", or items 23 the Medical Examiner must 31 Lambourne Road, #403 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry l Hygiene. other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Property Manager Real Estate other t Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental H ဂ္ဂ Margaret Elizabeth Henning Thomas H. Skidmore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trans C. David Heisler, Esq. (P.R.) 102 West Pennsylvania Avenue, Towson, MD 2204 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 D Cremation 3 Removal from State 4 Donation 5 Other (Specify) Green Mount Cemetery 1/5/2010 Baltimore, Maryland Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Láwson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arrest Tes Physician/ ardiac Medical Due to (or as a consequence of): Examiner ronary artery disease ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine ongestive vears Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical pertensio attending pl IF FEMALE 23c. If yes, outcome of pregnancy s, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes mellitus 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? 1 Yes 2 No this certificate completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1/2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check

State Registrar

within 2 To the

only one

29b. Signature and title of certifie

Carol Newill

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

7801 York Road.

egistrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

parker

44717

Suite #224. Towson, Maryland 21204

29d. Date signed (Month, Day, Year)

January

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend I State of Maryland & Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 03:17 PM James Shipley\_ 2010 Januarv Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Medical Center Baltimore Glen Burnie Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 11 1937 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 😾 M 2 🗆 F 213-32-3727 Dec. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 107 Temple Drive 21122 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White Specify: Completed 3 ☒ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Construction Home Improvement Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ James W. Shipley Ethel G. Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Madera 107 Temple Drive, Pasadena, MD 21122 (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 06 Jan. Meadowridge Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ DOIDC disease or condition Medical resulting in death) ue t (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the burial-transit the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for Month Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Parlensim 1 X Yes 2 No 3 Probably 4 Unknown Completed Nordscharote Cordionoscular 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗷 No Other: 0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and titl 29c: License number 29d, Date signed (Month, Dav. Year) person who completed cause of death (Item 23a) (Type, Print) Name and Mountain 31. Date filed (Month, L State

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of	Marylan		artment of tificate of		7	R	eg. No.2 U	10	00059
	Physicia /Medica Examine		1. Decedent's Name (First, Middle July)	SCOVEN	15					Date of Dea Month JAN	Day	Year	3. Time of Death 7. 2.3 A M
			4a. Facility Name (If not institution, give street and number)  Future CARE IRVINGTON				4b. City, Town, or Location of Death  BALTINORE				4c. County of Death		
	should be filed within 72 hours after death with the Maryland of Mental Hygiene.  In Mental Hygiene.  In marked other than "netural", or Itams 23e or 28e-f show and the than "netural be notified at the Medical Evaninal mental be notified at the Medical Evanination of the property.		5. Social Security Number		. Age (In yrs.		If Under 1 Yea	r If Unde	r 24 Hrs. R	Date of Birth (Month, Day 0 / 1 2 /	N/	9. Birtho	lace (State or Foreign Yngton DC
			218-42-4753 Usual Residence of Decedent	1 W 2 ZZ	6				1	0/12/	1941		
		Bec	10a. State 10b. County  MD N/A		10c. Cit	ty, Town or Lo Balti						1	0d. Inside City Limits 1 ☑ Yes 2 □ No
			MD N/A  10e. Street and Number			Батст	10f. Zip Code			1	log. Citizen of	What Cour	ntry?
			2509 W. Moshe	er Street		I.S. 13.1	1	1216	rigin? (Specif	v Yes or No-	U . S . P	ace · Americ	ean Indian,
980			1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Ford	ces? 2 X No 1		Was Decedent of 1 Yes, specify Cu 1 ☐ Yes 2 ▼ No			án, etc.)	Spec	ack, White, ify: Bla	
21215-0036			(Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed)  College (1-	4or 5+)	(Give	dent's Usual Occi kind of work don DO NOT use retir	e during mo red)			16b. Kind of		dustry
			11th Grade  17. Father's Name (First, Middle,	Last)		Pres	ser a s			First, Middle,	Maiden Suma		
Maryland			John 19a. Informant's Name/Relations	hin (Type Print)	Gra	ay SR	ng Address (Stree		h Adai		r. City or Tow	n. State. Zip	Code)
	nd 2 salth ar 27 is r treu		Robert Scoven			2509	W. Mos	her	st.,B	alto.	,MD 2	1216	
altimore,	000-		20a, Method of Disposition  1 XBurial 2 Cremation		late		sition (Name of matory or other pi		Date		20c. Location	•	
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	The taw requires that the death certificate be executed  We will be considered by the attending physician and page 2 should be detached for use as the burial-transit		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Peath										
			Immediate Cause (Final disease or condition resulting in death)  a										NICHOUN
		7.	Sequentially list conditions,	b. Due to lorge a consequence of the									
		Examiner	Sequentially list conditions, if any, leading to immediate caus. Entor Unacrying Cause (Disease or injury that initiated events resulting in death) Last	c. H.	c. HTPER TEN \$157							L	IN ICHOUN
68760,		Completed by Physician/Medical Example Completed by Physician/Medical Example Complete by Physician/Medical Example Completed by Physician Completed	resulting in death) Last			s a consequence of):  DOANEURYST OF ABDOMINAL AD					DRTA		NICHOUN
P.O. Box 6			Part II. Other significant continuous contributing to death out not resulting in the underlying cause given in Part.						_		l l	Date of deliver	ery Day Year
									<b>3</b>			co use contribute to the cause of death?	
I Records,									med?	prior to completion of cause of death?			
Vital	Physician: The this certificate ral director, page	o Be (	25. Was case referred to medica examiner?	Hospitals	unationt 2	ER/Outpatier	3 7 700		ce of Death (C		ne) lence 6 □C	that (English	60
of	Hospitel or Attending 4 hours after death. Funerel Director: After ely filled in by the fune	h	27. Manner of Death  1. Natural 5 Pendir 2 Accident investi	28a. Date o (Month		28b. Time o Injury	f 28c. Inj W		286		ow injury occ		97
Division		Certification:	3 Suicide 6 Could 4 Homicide determ	nined   286. Place	be 390 Blace of Injury - At home farm street factory office				281	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		edical C	29a. Certifier 1 Certifyii (Check only one) 2 Medical	ng Physician: To the Examiner: On the ba and mann	sis of examina	owledge, deat ation and/or in	h occurred at the vestigation, in my	time, date a opinion, de	and place, and eath occurred	d due to the o	cause(s) and date and place	manner as s e, and due t	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signal, re and title of certifie		ATTEND	1N6		nse number		ł	29d. Date sign		*
10	V		30. Name ind address of person	who completed cause	of death (Ite	m 23a) (Type	Print)	-					
¥			JANES TAM IND A 350 ARD M.7 PLACE SVITE 3H BATILDONE PD 21267  31. Date filed (Month, Day, Year) 0 5 2010 <sup>32. Registrar's Signature</sup> A. Janes										
	Sta Regist		JAN	0 5 2010	aneur	J. J.	Jarka						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician Barbara Segelken 12:30 A.M 2010 January 1, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Heart Homes Assisted Living Linthicum If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Months Days Hours 1 □ M 2 🖾 F 88 Yrs. 213 32 9996 England 02/13/1921 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a. State 1 ☐ Yes 2x No item 27 is marked other than "natural", or items 23a or 28a-f sl other traumatic event, the Medical Examinar must be inclined Director Linthicum Marvland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21090 123 North Long Cross Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: ۾ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental H Be Thomas Joseph Waidson Teresa Ellen Fletcher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Ccde) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sl ment of Health an ant: If item 27 is r Wiliam Segelken / Husband 123 North Long Cross Rd. Linthicum, Maryland 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition ortant: If i 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Crownsville, Maryland 01/05/2010 MD. St. Veteran Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ear 011 **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Exami that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical as the attending IF FFMALE for use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the aid d be detached for ☐Yes 2 ☐N6 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ Wo 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐No 1 Tyes 2 a No ours after death.

neral Director: After this certifical filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Letther (Specify Hospital: 2 DNO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27, Manner of Death Injury 1 Natural 5 | Pending 1 □Yes 2 □ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (SpecIfy) determined 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed ea

Year)

within 2 To the I

use of death (Item 23a) (Type,\_Print)

32. Registrar's Signature

29c. License number

200

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** AM RUTH GLADYS CATHERINE STUTELBERG 03 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Health and Rehabilitation Center If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, **Funeral** Hours Year) Min. 1 ☐ M 2 🔀 F Months Days Director 141-22-0711 82 Dec. 3, 1927 | New Jersey Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examinar must be notified 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1601 Martha Court 21015 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten than jujury or other traumatic event, the Medical Eventiral page. 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 № No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify ۾ 3 ₩ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter (nmn) Stewart Margaruite (nmn) Laub ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Stutelberg / Son 277 Trudy Ct., Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn. 1-7-2010 Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service License 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) pertension and burial-tran Due (fr as a consequence of) Division of Vital Records, P.O. Box 68760. iis certificate has been signed by the attending physician director, page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use Contribute to the cause of death? Ş 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an this certificate has autopsy performed? Yes 2 No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To in by the funeral 27. Manny r of Death 28b. Time of after death. 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 24 hours a filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the i the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M

State

31. Date filed (Month, Day,

Year)

32. Redistra

G. Stytelberg

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Santala Month Joyce 1056 2010 Medical Januar Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bayview Medical Hopkin Center Baltmore Johns 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Month, Day, Ye Days 1 🗆 M 2 💂 Months Hours Min. **Director** 219-28-6770 1932 Aug Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 🖾 No Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6744 Danville Avenue 21222 United States hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 21 No If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 ☑ Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe Roy Hedrick permit. Page 1 and 2 should be Department of Health and Men Important. If item 27 is marke any injury or other traumatic Luise Class 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6744 Danville Ave. Derek Santala (Son) Dundalk, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Hilltop Service Corp. 1/7/2010 4 Donation 5 Other (Specify) Towson, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 7<u>922 Wise Ave.</u> Dundalk, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) oura ton Medical s a conseq ence of) Due to (or Examiner INTERNAL. Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Cause (Disease or linjury Kenal tailure I week and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the ar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed should 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy perform death? 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 2010 ess of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Ave 2011911

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed

(Month, Day,

JAN 0 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROBERT MARSHALL TRACEY 2010 January 9:30 A<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 618 College Avenue Lutherville Baltimore County 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** . Age (In yrs. last birthday) 8. Date of Birth 1 ₹ M 2 □ F (Month, Day, Months Days Hours Min. 213-28-7780 Director 79 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. it item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Baltimore County Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 618 College Avenue 21093 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married δ Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor/ Meter Dept Gas & Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer Marshall Tracey Edna Pearl Hunt permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Virginia Tracey (Wife) 618 College Avenue, Lutherville, Maryland 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Green Mount Cemetery Jan 5,2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funorat Service Liberate

Martin D. Lawson Aleme and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, IN 6500 York Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death .Physician/ PROLIFERATI disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** counting list our little is if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 use as the l IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of of Do I Director: After t d in by the funera 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) the Hospital within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Gertifying Nurse Practioners to the best of my knowledge, death occurs det the time. 29b. Signature and title of detifie 29d. Date signed (Month. Dav. Year) me my 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21231 Steven Gore, M.D., Johns Hopkins Kimmell Oncology Center, 401 N Broadway, Balto, MD 31. Date filed (Month, Day, Year) 32. Register's Signature State Registrar

P.0.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per Verbal G899 1/05/10 Jh State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 20 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 2010 JAN. 04 6:30 A EUNICE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE RANDALLSTOWN #2 HOLSHIRE COURT Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Number **Funeral** Year) Days Months 1 □ M 2 🕱 F 88 Yrs. 1921 10 Director 217-14-3343 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Event Stormart be notified at 1 XYes 2 No Director MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21207 2121 WINDSOR MILL LANE APT. 232 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3₺ Widowed 4 ☐ Divorced BLACK Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. fitem 27 is marked other than HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be VIOLET JACKSON မ WILLIAM MILBURN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BALTIMORE, MD 21207 3409 DAYTA DRIVE DOUGLAS PRESS/NEPHEW 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 1-8-2010 BALTIMORE, MD MT. ZION CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. times (1 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CNOND Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examine Hospital or Attending Physician: The law requires that the ceath certificate be executed sician and burial-tran Due to (or a /a co equence of) attending physician for use es the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) 1 □ Yes 2 □ No signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performed 1 ☐Yes 2 18Ho 1 ☐ Yes 2 🖼 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home • Residence 6 Nother (Specify) neice's residence Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Medical Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0061439 J ANUARY 05, 2010 30. Name and address of person who completed cluss of death (Item 23a) (Type, Print) OLS COURT RS, RANDALL STOWN, MD 21133 M.D ADE 16MISI 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 05 201 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Vogelpohl Elimar 7:58 PM 01 010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore VA Medical Center Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F Days Min (Month, Day, Year) 02/25/1935 215-30-9358 74 **Director** Yrs VA Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1224 Kimberly Lane 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc. d Mental Hygiene. marked other than "natural", or i 1957 1 Never Married 2 Married 1 X Yes If Yes, Give Completed by 2 🔲 No Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🔀 No Specify: 3 Divorced 4 Divorced 1959 White Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Truck Driver Delivery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked John Vogelpohl, Sr. Catherine Cooper 19a. Informant's Name/Relationship (Type, Print) wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Patricia J. Vogelpohl 1224 Kimberly Lane, Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 KNBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 01/08/10 Crownsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD Singleton Funeral & Cremation Services, P.A. KO1357 23a. Part 1. Ever the dise, se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hand the fire. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic olon Cancer disease or condition bmonths Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami that the death certificate be executed and -trans Due to (or as a consequence of): resulting in death) Last burial Physician/Medical Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year 2 🗌 No 9 Unknown g \ Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performe page 2 No Yes 2 X No 1 Yes 25. Was case referred to medical examiner? Be Division of Vital 26. Place of Death (Check only one) funeral director Hospital Other: 2 💢 No 1 🗌 Yes ျ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury s after death. 2 🗆 No 1 Yes ☐ Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Funeral L Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Pwithin 2 State

DHMH 17 Rev 7/2009

Registrar

only one

29b. Signature and title of certifier

Meghan Dubina

5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

22 South Greene St.,

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

AU4176435D19647

Baltimore, MD

03

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 3:43 P.M Angeline Marie Vitellaro 2010 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Towson **Paltimore** 8. Date of Birth (Month, Day, Yo Mar. 10, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 Min. , 1918 Pennsylvania Months Hours Director 91 Mar. 198-01-9047 Usual Residence of Decedent or 28a-f shov notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland at Hygiene. Director 1 Yes 2XXNo Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Code "natural", or items 23a or dical Examiner must be n 10g. Citizen of What Country? United States Funeral 516 Kennington Road 21136 America 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2XXMarried þ 1 Yes 2XXNo Specify: If Yes, Give Year or Dates Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th other Seamstress Clothina Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is morany injury or other. Nicholas DePietro Antoinette Morano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Jones (Daughter) 2 Red Mile Court, Reisterstown, Maryland 21136 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Photospher (Specify Entombment Dulaney Valley Memorial Gardens January 2010 Timonium, Maryland Signature of Fundru Service Li 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Road, Owings Mills, MD 21117 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Impediate Cause (Final disase or condition resulting in death) Orset and Death tac M Physician/ ear Medical Due to (or as a cor sequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examine ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Yes ned by the a detached f Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signed should be 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Yes **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Gilchrist Hospital: 2 No Other: 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by ☐ Homicide determined 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar

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6701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BIN 67 B2. Registrar's Signature 25200

M. Charles St. Balto. Md 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #15 Per PHY (899 / 1/07/10 Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Louis Wayne Westerman Physician Wayne 2010 1 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner timore If Under 24 Hrs Date of Birth (Month, Day, Year) Oct 10, 9. Birthplace (State or Foreign last birthday Social Security Number 6. Sex Funeral 63 1 → M 2 □ F Months Days Hours Min. Country) Land 217-46-1572 1946 Director Usual Residence of Decedent 1∩a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show Examiner must be notified at 1 Yes 2 No MD Baltimore Parkville Director 28a-1 the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with Items 23a or 21234 1807 Wendover Road United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Deves Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married ō 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 Divorced 'natural', etram 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Unk Unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Westerman Edith Unk marked Louis Pages 1 and 2 should ပ and I 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig Westerman /Son 22 Glasshouse Garth Nottingham, MD 21236 f Health a timore, Jan 05 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Department of Important; If It any Injury or o 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nathrendatties mof Empity Funeral Alternatives M01443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760,lphaa consequence of physician by Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ьo in the past 12 months? Month 5 Other (specify) ed by the ald ☐Yes 2☐No 9□Unknown 9 Dunknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 : autopsy perform certificate To the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 🗸 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and

Registrar

State

30. Name a

·31. Date liled (Month, Day, Year)

pleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#2perPHYS, G899, 1/12/2010, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 3, Physician/ Charlotte 11:02 Watson 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 48 Old Granary Court Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year 1950 Pennsylvania 1 M 2 XF 59 Months Days Hours Min. Aug. 17 167- 42-8554 Director Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2817 Seasons Way 21401 United States should be filed within 72 hours after death vand Mental Hygiene.
is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. White or, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 X Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
American Society of 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Certified Public Accountant Engineering Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Walter Davies Mary Lou Grawe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health : Charlotte Souder/ Daughter 275 Whistling Pine Road Severna Park, Maryland 21146 permit. Page 1 and 2 Department of Healt Important: If item 2 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) injury or 1 Burial 2 X Cremation 3 Removal from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Fjuneral Service Licens ec Alice Iser 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death OVARIAN Physician/ MONTHS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has performed certificate 2 No Yes 2 🔀 No 1 Yes Division of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗷 No 1 Yes ဂ္ ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 K Other (Specify) Friends Home within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. 5 Pending 1 🔀 Natural 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 043934 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLACE BALTIMORE WW 51205 PAUL 21 32. Registrar's signatur State Registrar

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ Month Shirley Catherine Winterling 1:55 Αм January 3. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Middle River 3944 New Section Rd. 8. Date of Birth
(Month, Day, Y
Dec. 6. 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 1 □ M 2 🔀 F Director 213 28 5172 78 1932 Marvland Usual Residence of Decedent works i 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ld be filed within 72 hours after death with the Maryland Mental Hygiene. ral", or items 23a or 28a-f sho Examiner must be notified at rector Middle River Maryland Baltimore 1 Yes 2 X No Ö 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21220 USA 3944 New Section Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 9 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. White 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o Marie Williams George Hutson traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sl tment of Health a tant: If item 27 i 3944 New Section Rd. Baltimore, Maryland 21220 Paul Leo Winterling Jr.(Husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Sacred Heart Of Jesus 1/6/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex 21. Signature of Funeral Service Licensee W. Maryland 21221 23a. Far 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequent of) Examiner Sequentially list conditions, Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Year Pregnant at time of death 2 🔀 No 1 Yes 2 X 9 Unknown 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed?

1 Yes 2 X No 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to Certificate: To Be examiner? Hospital: Other: 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Hospital 24 hours Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) atarasio mo

Registrar

Ronald Attanasio M.D. 9114 Philadelphia Rd. Baltimore, Maryland 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 0 4 2010

D28097

January 4, 2010

P.O. Box 68760. Records, Vital Division of

the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deat To the Funeral Director: completely

filled in by

State Registrar

4 Homicide

(Check only one)

29b. Signature and the of certifier

29a. Certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature

and manner stated.

5601 Loch Raven Boulevard, Baltimore Maryland 21239

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

25391

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2010

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	ertment of ertificate of			iene <sub>9g. No.</sub> 2010	00072	
			Decedent's Name (First, Middle, Last)						Date of Death     3. Time of Death		
Physic		_	LESTER	EMORE		JANUARY	3, 2010	7:26 P.™			
14.	/Medic Examin	_	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town,	or Location of Deat	th	4c. County of Dea	th	
4			100 WALDON ROAD	APT. A					HARFORD		
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday	Months Day		(Month, Day,	Year) C	thplace (State or Foreign ountry)	
	Director		246-30-6383		79			12/22/1	930 NOF	RTH CAROLINA	
			Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation.				10d. Inside City Limits	
	Maryl f sho	호	MD HARFORI		ABING	OON				1 □Yes 2X No	
	the 7	Director	10e. Street and Number			10f. Zip Code	)	1	0g. Citizen of What C	ountry?	
	3a o	교	100 WALDON ROAD	APT. A		2100	9		USA		
	death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13	. Was Decedent of	f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whit		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ita Madical Evanime must be naithed at	by Fu	1 Never Married 2 Married 3 Widowed 4 Moivorced	1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	lo	1 □Yes 2 ☐KN		,	Specify: WI		
215-0036	tural		15. Decedent's Educ	cation	16a. Dec	edent's Usual Occ	upation		16b. Kind of Business	/Industry	
215	in 72 in "na Media	Completed	(Specify only highest grade	completed) College (1-4or 5	life.	e kind of work don DO NOT use reti	ne during most of wo red)	rking			
212	d with giene ar tha	ĕ	3RD GRADE	College (1-40) 5		ACHINIST			BLACK & DE	ECKER	
	al Hy l othe	Be C	17. Father's Name (First, Middle, Last)					me (First, Middle, I			
/lai	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	၉	WM. HENRY BAZEMO	RE		,	MYRTL	E GILLIKI	N		
Maryland	2 sho and Is ma		19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mai	ling Address (Stre	et and Number or F	lural Route Number	, City or Town, State,	Zip Code)	
≥,<	permit, Pages 1 and 2 Department of Health s Important: If item 27 Is any injury or other tra once.		HENRY BAZEMORE/SON			2 LESLIE			MD 21222 20c. Location - City of	r Town State	
Baltimore,	ges 1 t of H if ite or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	emoval from State	20b. Place of Disp cemetery, cr	ematory or other p			200. Editation - City of	Town, State	
ţ	t, Pag tmen tant: jury		4 ☐ Donation 5 ☐ Other (Specify)			EW CEMET			ROCKY MOUN		
Bal	permit Depar Impor any ir		21. Signature of Funeral Service License	● MOO217						HOME, P.A.	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or compli	actions that sourced			I RAVEN BI			1286 Approximate	
			shock, or heart failure. List only or Immediate Cause (Final	ne cause on each lin	e.					Interval Between Onset and Death	
			disease or condition resulting in death)	recti			3 MINUTES				
7				0-20	a consequence of):	12781	zy Di	SEASE		30 YEARS	
		ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of).							
	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Examine	Cause (Disease or injury that initiated events	:							
Ö,	e exe ian a urial-t	Ä	resulting in death) Last	Due to (or as	a consequence of):						
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Box	attend for us	Physician/Me	in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death 3	B ☐ Ectopic pregna			23d. Date of d Month	Day Year	
Ö	the de	ysic	1 □Yes 2 □No 9 □ Unknown	9 Unknown	tume or death	o ⊟ Other (s <i>pecity,</i>	/ <del></del>				
σ.	that the de ned by the a detached f		Part II. Other significant conditions con	ntributing to death bu	ut not resulting in the	underlying cause	given in Part I.	23e. Did to	bacco use contribute	to the cause of de. ?	
Records,	uires than signed Id be det	Completed by	MYPERTENSIO	PV, 57	BUKE	CHRU	×//C	. 1□Y	es 2□No 3□I	Probably 4 Unknown	
00	w requir s been s should	ete	PENA INGUIFICIENCY 24a. W						in 24b. Were a	autopsy findings available	
Re	he lav e has ge 2	Ę.		, , , ,				autops perfor	med?// death?	completion of cause of	
tal	n: Th fficate or, pa		25. Was case referred to medical	<u></u>			26. Place of De	1 □ Yes eath (Check only or		es 2 No	
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o	dIng Phys h. After this i funeral dir	n:	27. Mann of Death	28a. Date of Inju (Month, Da	ry 28b. Time	of 28c. Ir	njury at Vork?		ow injury occurred		
<u>ö</u>	Attending it death. ector: After by the fune	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		□Yes 2□No		<u> </u>		
Division of Vital	I or Attendl after death. Director: A I in by the fu	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, farm, : c. (Specify)	street, factory, offic	e	28f. Location (S City or Tow	treet and Number or I n, State)	Rural Route Number,	
	urs af ral Di			1.1	and an account of the country of the	oth posture district	e time determination	en and due to the	aguag(a) and mann-	as stated	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	ner: On the basis o and manner sta	f examination and/or	investigation, in n	e time, date and pia ny opinion, death oc	ce, and due to the c curred at the time, c	cause(s) and manner date and place, and di	ue to the cause(s)	
	To the within To the compl	Me	29b. Signature and title of certifier	1			ense number		29d. Date signed (Month, Day, Year)		
			9-1-6/6		- pup	0	53095	5	Towurey	4, 7010	
			30. Name and address of person who co		eath (Item 23a) (Typ	e, Print)	A sit			4, 7010 MD 21093	
				up 1	TEXAG	STATIO	VCT. TO	210 /10	non cun	MA) 61073	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	hove					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #20bPer FH G899 1/06/10 18294 Please Type (1899) 1/06/10JH

State of Maryland Department of Health and Merita 1999 1606/10JH

		-	For State Registrar		State of Ma	aryiano	_	tificate of L		na we		giene Reg. No		00072
	Dharisis	/	1. Decedent's Name (First, N							2.	Date of Dea	n+h	2010	3. Time of Death
	Physicia Medic		LAWR		RUSSELL	BIRD					Januar		2, 2010	
	Examin	er	4a. Facility Name (if not instit 606 Carroll		eet and number)			4b. City, Town, or Laure		Death			. County of Death Prince G	
	Funeral		5. Social Security Number	6. Sex		e (In yrs. la	st birthday)	If Under 1 Year	If Under 2		Date of Birt	h	9, Birth	place (State or Foreign
	Director		213-24-3418		1 ☑XM 2 □ F 79 Yrs. Months Days Hours Min. (Month, Day, Ye June 15,						, Year)	930 New	York	
	show	ō	Usual Residence of Deceder 10a. State 10b. Co			10c. City	Town or Loc	ation						10d. Inside City Limits
	Maryla 28a-f s stified	Director	MD Pri	nce Ge	orge's	Lau	rel							1xxYes 2 ☐ No
	h the		10e. Street and Number					10f. Zip Code					tizen of What Cou	intry?
	ath wit	Funeral	606 Carroll 7		2. Was Decedent E	ver in II S	13 V	20707	dispanic Origin? (Specify Yes or No-			U.S.	A .  14. Race - Ameri	icen Indian
9	er deg	by F	1 ☐ Never Married 2 <b>X</b>		Armed Forces? 1 ☐ Yes 2 🛣		l lf	Yes, specify Cuba	ın, Mexican,	Puerto Rica	an, etc.)	n, etc.) Black,		, etc.
8	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ted	3 Widowed 4 Divo		If Yes, Give Year or Dates.		1 □ Yes 2 <b>XM</b> lo Specify:					Specify: White		
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Baltimore,	. Page 1 tment of <b>tant: If it</b> <b>jury or o</b>		4 Donation 5 Ct		emovar from State		Arunde	1 Cremat	ory 0	1/04,	<del>/2009</del>		enton, M	aryland
Ball	permit. Page 1 Department of Important: If is any injury or of		21. Signature of Funeral Ser	vice Licensee	/	M007	70 3	onaidson 13 Talbo	ssfliner tt Ave	al Ho enue	ome, P Laure	.A. 1, N	Maryland	20707
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Box 68	death certif ne attending ed for use a	ian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23	c. If yes, outcome	2 Fetal	death 3	Ectopic pregnand	су			1	23d. Date of deli	
Bo	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/M	1 ☐ Yes 2 ♠No 9 ☐ Unknown		4 ☐ Pregnant a 9 ☐ Unknown	t time of de	eath 5∟	Other (specify)					MONUT	Day Year
P.O.	that the ned by a detail	by Pł	Part II. Other significant co	nditions cont	ributing to death b	ut not resu	Iting in the ur	nderlying cause gi	ven in Part I.		23e. Did to	bacco u	use contribute to	the cause of death?
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Ä	n: The ficate or, pag		25. Was case referred to med	dical				06 DI	ace of Death	(Ch==1; ==	1 Yes	rmed2 2 No		2 No
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_	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach	Medical	(Check 2 Medi	ical Examine	ian: To the best of r: On the basis of ex Practioner: To the	xamination	and/or investi	gation, in my opinio	on, death occ	turred at the	time, date a	nd place	, and due to the ca	ause(s) and manner stated.
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_	BV		30. Name and address of pe	rson who con	4 ( ( ) )	eath (Item :	BQ V	deve 1	tren	ne;	Bal	hm	ore, MI	21215
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10-00025 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Kiona Lovely Burrell 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 2, 2010 0220 hrs Medical Examiner LOVEIV KIONA BURRELL 4a. Facility Name (if not institution, give sifeet and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 600 W. Patapsco Avenue 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign MARY/AND Min. Director 23 04 217-11-9149 Country) 1 M 2**X** F Usual Residence of Decedent 10d. Inside City Limits BALTIMORE 1 Yes 2 No MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10e. Street and Number 10g. Citizen of What Country? 21215 2407 LOYOLA NORTHWAY Ö Race - American Indian, Black, White, etc. Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: BLACK If Yes, Give Year or Dates: 3 Widowed 4 Divorced 1 Yes 2 No specify: If frem 27 is marked other than "natural , ... "--- matic event, the Medical Examiner à 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) TRANSPORTATION 21215-0036 School Bus DRIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) KENNITH ANTHONY BURK 19a. Informant's Name/Relationship (Type, Pri/ht) GRAND-CINDW Be BURRELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/2/3 2 mother MAE BURRELL 4802 NORWOOD 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State BALTIMORE, MARYLAND PARK CEME 2010 Donation 5 Other Specify 21. Signature of Funeral Service Licens PARK HGTS. AVE. MAR Physician Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and failure. List only one cause on each line /Medical a. Head and neck Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed sician/Medical AMENDED UNPENDED attending physician or use as the burial Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Month Day Year past 12 months? 2 Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ģ σ. Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of After this certificate has performed death? 1 🗸 Yes ✓ Yes 2 2 No 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗹 Other: Scene ER/Outpatient 3 1 V Yes 28a. Date of Injury (Month. Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Passenger ejected from vehicle Jan 2, 2010 Natural Division 1 Yes 2 ✓ No Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide Could not be or Town, State) 600 W. Patapsco Avenue, Baltimore, MD (Specify) Major Road To the Funeral Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. January 2, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Ana Rubio MD. 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature 31. Date filed (Month, State arka Registrar

DHMH 17 Rev 1/2001 OCME 2006 OCME

**ORIGINAL** 

Jan 4 Day **Physician** Billin Barbara Ann /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederiak Frederick Sunrise Assisted Living If Under 1 Year | If Under 24 Hrs. 5. Social Secure 3121 per 6. Sex 8. Date of Birth (Month, Day, May 21 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 F Months Days Hours 71 Yrs ĭ938 041 - 30 - 8325May Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show event, the Medical Examiner must be notified at Carrol1 Mt. Airy MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 21771 3410 W. Watersville Road by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ∐Yes 2**X** No 3 ☐ Widowed 4 🖾 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Interior Designer 12 and Mental Hygi 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Pages 1 and 2 should be Barmore Eugene Francis Billin Gertrude injury or other traumatic ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3430 W. Watersville Road, Mt. Airy, MD 21771 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 Is
any injury or other trau daughter Diana Beuchert 20b. Place of Disposition (Name of cemetery, crematory or other place)

South Carroll Crematory 6 2010 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Winfield, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Septice Vice 22. Name and Address of FacilityBurrier-Queen Funeral Home, P. A. 1212 West Old Liberty Road, Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. <u>ک</u> Completed

State Registrar Amend#5perFH, g902, 4/13/2010, WS

1. Decedent's Name (First, Middle, Last)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify, 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 □ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene?

Certificate of Death

Reg. No.

US

Specify

201<sup>°</sup>0° ar

3 Time of Death

Рм

3:10

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 ☐ Yes 2XCXNo

PA (Country)

14. Race - American Indian,

White

Black, White, etc.

2 Date of Death

23d. Date of delivery

Month

10 32. Registrar's Signature

State Registrar

certificate has

this

ours after death. Heral Director: A filled in by the fu

within 24 hours a

Division

Be

Certification: To

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mary Jane Buhl 2010 9:00 A. M Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1613 Davinda Drive Carroll Finksburg Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Feb. 26, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔯 F 89 216-01-9653A Maryland Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if than "natural", or items 23a or 28a-f sho Maryland Carroll Finksburg 1 ☐Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? hours after death with 1613 Davinda Drive 21048 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2x(No Specify: Specify: White 2 3 √Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation within 72 (Give kind of work done during most of working life. DO NOT use retired) or and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than "n. wher traumatic event Bendix and Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Co. Inspector 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Velton Suzannah Potcova 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If Item 27 is any Injury or other trau once. Son James W. Buhl, Jr. 1613 Davinda Drive Finksburg, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem. Park Jan. 8, 2010 Sykesville, MD 4 □ Donation 5 □ Other (Specify) Burrier-Queen Funeral Home & Crematory, PA
1212 W. Old Liberty Road Winfield, MD 21784
Approximate of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immeriate use (Final Physician ounce /Medical Due to (or as premeduence of Examiner Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-transit Physician: The law requires that the death certificate be executed Box 68760, Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month 5 Other (specify) signed by the a Id be detached fo Ö ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u></u> Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 □ Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred e Hospital or Attending P 124 hours after death. e Funeral Director: After t letely filled in by the funera 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 1xCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature ap 29d. Date signed (Month, Day, Year) 2010 035556 npleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day 32. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 01 20<sup>Ye</sup>ar Joseph Lewis Burghauser, Sr. 5:20 AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Towson <u>Gilchrist Hospice</u> 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** .Sex 1 XM 2 □ F (Month, Day, Year) 07/26/1923 Days Hours l<u>inois</u> Min. Director 86 187-12-1710 show 10a. State within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore 1 Yes 2 X No. MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 U.S.A. 9406 Philadelphia Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, was Decedent Ever in U.S Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. ₩₩ II Black. White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Genstar Machine Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Burulcich should be Jospeh Burghauser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Ivy Trace Court - Cockeysville, Maryland 21030 Linda Andrews (daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gardens of FAith Cem. 01/05/2010 | Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 00 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 119 emen Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death ped the g Unknown 9 Unknown detach ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be d 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform After this certificate 2 DLN 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Dether (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No Investigation Accident the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0061199

State Registrar

North

Registrar's Signatu

Charks St. Suit 4105 Touson mo 212041

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Blac

31. Date filed (Month

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #29d Per DVR G899 1/06/10 JH State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** S. Butler Januar 6.00 AM Inez 9010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore St. Agres Huspital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2√2 F 100 Director MD 217**-**05-4793 09 09 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the fred of Earl has a unit be malified at 1 XYes 2 No Director Baltimore MD NA 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number U.S.A. 21216 2813 Windsor Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes — No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛛 No Specify: If Yes, Give Year or Dates: Specify: Black by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other than Clerk Hutzler's 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 9 Mamie Russell <u> Matthew</u> Slowe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2739 Winchester Street, Baltimore, Md 21216 Frank Jones-Son permit. Pages 1 and Department of Healt Important; If item 2 any injury or other item 2 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1/8/2010 4 ☐ Donation 5 ☐ Other (Specify) Arbutue Memorial Arbutus, Md 21. Signature of Funeral Service Licensee Marchand Address of acility 4300 Wabash Ave, Baltimore, Md 21215 N hompen 23a. Part 1. Ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate larse (Final disease or condition resulting in death) MYOCHRDIAL INI-ARCTION CUTE **Physician** UNKTUONA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a cur securing off physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) P.O. detached 9 Unknown 9 Unknown signed by it be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ş 2 No 3 Probably 4 Unknown 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has triector, page 2 sl 1 □Yes 2 □No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ( Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After To the Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number
29d. Date signed (Month, Day, Year) 201

DCO 5/865

TANGARY 1, 2004 29d. Date signed (Month, Day, Year) 2010 29b. Signature and title of certifier Les 30. Name\_and address of person who completed cause of death (Item 23a) (Type, Print) MENS HUSPITM BALTTMORE, MI) 57 1ARLLES

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Mo

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2018 **Physician** BEI /Medical 4a. Facility Name (If not institution, give street and number) 4b. Gitv. Town, or Location of Death 4c. County of Death Examiner Salto Northwest 5 Rasons PICE Date of Birth (Month, Day, Y 5. Social Security Number 7. Age (In yrs. last billinday If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Qountry) **Funeral** Days Months 1**≸** M 2□ F 227-46-255 Director 9/11/9 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedgall Event has mut by motified any pince. Director 1 ☐Yes 2 No STOU 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 212 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify ģ 3 ☐ Widowed 4 ☐ Divorced lack Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) anagei 18. Mother's Name (First, Middle, Maiden Surnar 17. Father's Name (First, Middle, Last) Be *+d* ber W/e ೨ OL 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) fэ 2124 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of F Service 91 arla Ker 701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** REBRA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2500 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide

State Registrar

OL 31. Date filed (Month, Day, Year) JAN 0 6 2010

29a. Certifier (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 32. Registrar's Signature

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

\*\*Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

License number

Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Carolyn L. Chavis 02.50 AM KARUNAR 05 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** n/a BALTIMORE AGINES HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 💆 F Months Days 62 5/28/1947 Maryland **Director** 212-48-2050 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show 1 XYes 2 No Director Baltimore MD n/a 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21230 USA 1962 Sponson Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 🎇 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Food Store Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event once. Be James Channell Dorothy Sanders 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1719 Rittenhouse Avenue, Baltimore, MD 21227 Lutana Aguilera / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 1/8/2010 Baltimore, Maryland 4☐ Bonation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signatu e of Funeral Service License 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Immediate Cause (Final disease or condition resulting in death) **Physician** OBSTRUCTIVE PULMONARY DISEAS CHRONIC 25 YEARS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off. The law requires that the death certificate be executed Due to (or as a consequence of) 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 XNo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 □Yes 2 □ No 2 ☐ Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P22004 JANUARY, 05, 2010

State Registrar DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

ANUSHA IYER

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ORIGINAL

CATON AVENUE, BALTIMORE, MD 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DeAubery Lynn Dailey 200P Janhan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Bring Baltimore-Washington Medical Ctr. If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X 215-92-4742 43 Director Maryland 07/17/1966 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Anne Arundel Severna Park 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 175 B & A Boulevard South 21146 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Yes 2 X No δ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 (al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even Robert Sizemore Kathleen Buie Housand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Travis Dulaney Smith/Son 175 B&A Blvd., Severna Park, MD Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemeter, crematory or other place)
Ardent Cremation Services 01/05/2010 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service Licensee SOK 7522 Connelley Drive, Ste.N, Hanover, MD 21076 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** concer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine attending physician and for use as the bunal-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Division of Vital Records, P.O. Box Month Year Day Pregnant at time of death been signed by the should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has build director, page 2 sh autopsy performed 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 I Yes patient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work Accident 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifie Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the 1 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title 29b. Signature at of certifier 29d Date signed (Month of person who completed cause of death (Item 23a) (Type, Print) Name and addre DAS 31. Date filed (Mont) 10 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 11.20b per fh g899 1-6-10 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 2. Date of Death 1. Decedent's Name (First, Middle, Last) EQ. Month Year 7.40 PM 100 **Physician** James oun ) GHNERY 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.
Months Davs Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (in vrs. last birthday) 5. Social Security Number **Funeral** 1 №M 2 🗆 F Days July 20, 1938 216-34-522 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 23a or 28a-f show must be notified at 1 Yes 2 □ No Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S.
Armed Forces?
1 Aryes 2 □ No Armed If Yes, Give
Year or Dates: USA Funeral 21210 Roland 4444 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status the Medical Examiner 2 No Army 1 Never Married 2 Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: \$ 3 ☐ Widowed → Pivorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. other than " College (1-4 or 5+) Elementary/Secondary (0-12) Printino 19 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental if Health and Menta item 27 is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jaseph Dolan 19a, Informant's Name/Relationship (Type, Print) ပ traumatic Roland Springs Dr. ion (Name of Lunk. Date Dolan / Spouse BaltonMD 21910 4444 Juanne other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition permit. Pages 1
Department of I
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State o Cremetory
22. Name and Address of Facility Baltimore, MD 4 Donation 5 Other (Specify) etro 21. Signature of Europral Service Licensee 18434 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 1 1232 Midvalley 23a. Pin 1 Inter the disease, or complications that cause shock or heart failure. List only one cause on each line. Approximate Interval Between Hypotension Immediate Cause (Final disease or condition resulting in death) Physician /Medical r as a consequence of): Examiner CANCER Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Examiner Due to the earle econocourrier of The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? Month 5 Other (specify) 1 Yes 2 No Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 TYes or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner?

1 Yes 2 No Hospital: 1 Inpatient Other: 4  $\square$  Nursing Home 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ၉ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 1 Natural 2 Accident Injury 5 Pending investigation 2 🗌 No 1 TYes 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only 29c. License number 29b. Signature and title of certifier RF5-000 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 600 North Wolfe St, Baltimore, MD, 21287

Greenberg

32. Registrar's Signature

Ceiko

31. Date filed (Month, Day, Year)

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Physicia Iedical Examir	_	David Michael	Dixon	G								Month January 2	Day , 2010	Year	1040 hrs	
		4a. Facility Name (if not institution 40 Towns Court	n, give street and n	umber)			41	b. City, Tov Roseda		ocation of I	Death			unty of Deatl more Cou		
Funeral		5. Social Security Number	6. Sex	7. Age (	(In yrs. la	st birthday	y)	If Under		If Under 2		8. Date of Bir	th(MM/DD/		thplace (State or	
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D 21215-00; should be filed within and Mental Hygiene. Tis marked other unatic event, the Medianic event,	o Be	David R. Dixon  19a. Informant's Name/Relations		Cynthia Casper  19b. Mailing Address (Street and Number or Rural Route Number, City or						Town State	Zin Code)					
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 'item 27 is marked other than "natural", or items 23a or 28a-f she r traumatic event, the Medical Examiner must be notified at once	-	David R. Dixon	(Father	)		1	_		•			1D 2115			,,,	
e, M 1 and 2 Health Fitem 2		20a. Method of Disposition	0 D D			lace of Dis	sposit	ion (Name	of ceme	etery,		Date	20c. Loca	tion - City or	Town, State	
MOF Pages ] sent of J tnt; If		1 X Burial 2 Cremation 4 Donation 5 Other Sp		rom State	7	-		f Fai	th		01-0	7-2010	Balt	imore	, MD	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other ir		21. Signature of Funeral Service	Licensee												ne of BelAir	
- 3-7	_	23a. Part I. Enter the disease, or	complications that of	saused th	e death							Rd Bel			Approximate Interval	
Physician /Medical		failure. List only one cause	on each line.						zy ig, oc	aor ao car	3140 01 1	oopii atory arre	sot, onlook, t	, Hourt	Between Onset and Death	
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Box 68760 death certificate bhe attending physid for use as the bu	sician/Me	past 12 months?	I LIVE I		ne of dea	2 ith 5		il death <sub>er</sub> <i>(Specif</i> y	3	Ectopic p	regnand	У	Mon	ith [	Day Year	
BOy e death the att	Physi	1 Yes 2 No 9 Unk	nown g Unkn	own			Our	UI (=)====								
	by P	Part II. Other significant conditi	ions contributing to	o death b	out not res	sulting in t	he un	derlying ca	iuse giv	en in Part	I.	23e. Did to		_	the cause of death? bably 4 Unknown	
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/ital	o Be	examiner?	Hospital:	Inpatient	2 E	ER/Outpat	tient		10	thos:			Residence	6 🗸 Other	: Scene	
Division of Vital Records, tal or Attending Physician: The law requints after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	⊢⊦	27. Manner of Death	28a. Date (Mont)	of Injury n, Day,Year	r) :	28b. Time	of Inj	ury 28d	_	at Work?		Bd. Describe h	now injury o	ccurred	_	
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Divis	Certification:	deter	d not be 28e. Place (Specify)	h	y - At hor <b>10USE</b>		street,	, factory, of	fice bui	lding, etc.	120 1R	or Town, Sosedal	tate) HO	LOWNS	Route Number, City	
Hospit Hospit Funera		4 Homicide  29a. Certifier 1 Certifying Pt	nysician: To the be		nowledge	e, death o	ccurre	ed at the tin	ne, date	and place				nner as state	ed.	
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F > F 0	ž	29b. Signature and title of certifie	1						icense r						nth, Day, Year)	
		Mujerie Mel	frell						D.C.M.	. C.			January	3, 2010		
$\varphi$		<ol> <li>Name and address of person Margarita Korell MD.</li> </ol>	who completed cau Assistant Me				1 Pe	nn Stree	t, Bal	timore, I	MD 21	201				
Sta	ite	31. Date filed (Mbrth), Day, 100			Sylnatur							-				
Registr		MADRA A A COL	Carried States		F12 1 10	COLOR COLOR	1200									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Month 9:45 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glichnst Baltimor Ll Baltimore 7. Age (In yrs. last birthday) 86 <sub>yrs</sub> 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours 0971471923 Director 185-12-0700 Usual Residence of Decedent In than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10302 CASCADE RUN COURT 21117 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify: Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) CONTRACTOR CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F MAX DANIELS BESSIE other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 1010 ASPEN DRIVE, IMPERIAL, LYNNE ZVIRMAN / DAUGHTER PA 15126 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State njury or 4 ☐ Donation 5 ☐ Other (Specify) 01/05/2010 REISTERSTOWN, MD BALTIMORE HEBREW 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ brain disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner of Non-small Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine 0+ Cause (Disease or iinjury the bunial-tran that initiated events resulting in death) Last Due to (or as a nsequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day been signed by the a should be detached t the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 Z No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D68286 anuary

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NO

Registrar's Signature

Natalle E

JAN 0 6 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ene 4:52 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Bultmore Gluns baltimore OSDICE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 NJ Social Security Number **Funeral** 6. Sex Age (In yrs. last birthday) Days Min. 1 M 2 XF 672074937 Director 72 214-34-7979 Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Carrol1 New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21776 USA 307 Church Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. and Mental Hygiene. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3XXWidowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Arlington Baptist Church Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Irene Caroline McUin William E. Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sł Department of Health a Important: If item 27 is P.O. Box 373, New Windsor, MD 21776 Elizabeth Combass 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 1/7/10 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. Cem. Owings Mills, MD 21. Signature of Fineral Service Licenses Burrier Queen Facility Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ anan Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cauca. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atten for us 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 X No Month Year signed by the a d be detached i 9 Unknowh P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? <u></u> with Psychotic Features Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed Yes 2 certificate Division of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 000 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) After t 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending 5 Pending injury 1 🗌 Yes after death. 2 No 2 Accident
3 Suicide Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 068286 er 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

MP

32/Registrar's Signature

N. Charles

Baltimore, MD 21204

Please Type or Brint in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 8 per fh 8899 1-19-10 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Jack Delaney Freeman 2110 PM 3 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner FRANKLIN SQUARE HOSPITCI Center BalTimore 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 54 Director 218 68 5450 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show 10a, State item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, Its Mydical Evanities must be notified at 1 □Yes 2 No Director Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 USA 1741 Earhart Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 XNo Specify δ 3 ☐ Widowed 4 X Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Item and Injury or other traumatic event, Item Mental Automotive 12 Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Farlene Putman Darrel Dayton Freeman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Middle River, Maryland 21220 Christopher J. Freeman (son) 12 Yawmeter Drive Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens 1/7/2010 Baltimore County, Md. 4☐Donation 5 ☐Other (Specify) 21. Sign take of Funeral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Dause (Final disease occondition resulting in death)

a. Ventri **Physician** ventricular Fibrillation /Medical Due to (or as a consequence of): Examiner DILATEd cardiomyogath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-trai resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the attending IF FEMALE nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No signed by the a 9 Unknown 9 Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed' certificate 1 □ Yes 2 1No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

σ. Division of Vital Records, Hospital or Attending

Box 68760.

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Baltimore, Maryland 21215-0036

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State Registra

29b. Signature and title of certifler

OR mohamad Alabrash

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

037612

FRANKLIN Square DR Balto

29d. Date signed (Month, Day, Year)

3

md 21237

,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 4:00 A 1 2010 1 Roselma Ruth /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Fairfield Nursing Home Crownsville 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours Months 1 □ M 2 🗓 F Yrs 1-3-1928 Pennsylvania Director 216-24-5919 81 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director 28a-f Maryland | Anne Arundel Crownsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò within 72 hours after death with or items 23a United States 21032 1454 Fairfield Loop Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes. Give Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) yes I and 2 should be filed within tof Health and Mental Hygiene. Elementary/Secondary (0-12) than College (1-4or 5+) Education Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edna Helen Lampke ဂ္ဂ <u>John Ellis Bruckman</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 107 Main Ave. SW; Glen Burnie, MD 21061 <u>Eloise Kellenberger / Sister</u> permit. Pages 1 a
Department of Hei
Important: If item
any Injury or othe 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 1 □ Donation Meadowridge Mem. Park: 1-6-2010 Elkridge, Maryland 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy. SE; Glen Burnie, 21. Cignature or ral Ser 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Mumania /Medical Die to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for L Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 □Yes 2 No P.0. the detached 9 Unknown 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 No 1 ☐Yes 2 No Division of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred al or Attending Piss after death.

al Director: After ted in by the funera After t 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of

State Registrar

DHMH 17 Rev 1/2001

Crain Mychwas

address of person who completed cause of death (Item 23a) (Type, Print)

(Month, Day, Year,

208

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 04 2010 JANUAR Physician/ SHERMAN HOOVER 12:05 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARbUR HUSPITAL N/A Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours 214-54-8413 60 August Day 8 Pear 1949 Virginia Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Brooklyn Park 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 Funeral 523 Cresswell Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Ilmportant if item 27 is marked other than any injury or other trainment. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Warehouseman G.T.S. Wilco Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Hullihen Sherman H. Foster Sr. Bertha A. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 523 Cresswell Road, Brooklyn Park, Maryland 21225 Margaret Negatatan (sister) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Cedar Hill Cenetery 01-08-10 Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility McCully—Polyniak Funeral Home P.A. 237 East Patapsco Avenue, Baltimore, Maryland 21225 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAL Physician/ DYSPHITHMIA Medical Examiner innedist MYOCARDIAL INFANC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Ducito (or as a consequence of, and I-transit CORONARY Hospital or Attending Physician: The law requires that the death certificate be executed Anteny Disease 7-Call that initiated events Due to (or as a consequence of) resulting in death) Last physician are the burial-t Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Yes 2 No ed by the a 9 Unknown 9 Linknown 124 hours after death.
124 hours after death.
e Funeral Director. After this certificate has been signed by to a finer in by the funeral director, page 2 should be detact. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? PERIPHERAL VISCUIM DISEASE 24a. Was an autopsy 1 ☐ Yes 2 ☑ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examine? Hospital 2 🗌 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

3001

AMBREW BUKEVITZ M.D

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 06

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00061438

JANUARY 04

Soft Hanover St. Balkmon MD 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 16:30 PM 01 03 2010 Edward S. Groft /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Year) Days Hours 1**X** M 2□ F 10/29/1930 Maryland 79 Director 214-26-9673 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experience mate the redified at 1 ☐ Yes 2 ☑ No Director Fallston MD Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 1324 Murgatroyd Road 21047 12. Was Decedent Ever in U.S. Armed Forces? 1X]Yes 2□No IfYes, Give Korean Year or Dates Hostil. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after call Hygiene.

other than "natural", or iter 1 Never Married 2X Married 1 ☐ Yes 2X No 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Clerk Supermarket 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Schaffer Lawrence Groft 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (wife) 1324 Murgatroyd Road - Fallston, Maryland 21047 Dorothy M. Groft Baltimore, permit. Pages 1 a
Department of He.
Important: If item
any Injury or othe 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 01/07/2010 | Fallston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Highview Mem. Gdns. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. C. 8 Xassa 21087 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ke disease or condition resulting in death) 119 lui /Medical Due to (or as a consequence of) Examiner 5 Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as monsequence of) Due to (or as a consequence of) that the death certificate be Physician/Medical 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 Other (specify) □Yes 2□No 9 Unknown o 9 D Unknown σ, 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ Tai 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The performed certificate 1 ☐ Yes 2 ☐ No 1 □Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ot 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Yes 2 No Division or Attending 5 Pending investigation NMA 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0069927 ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UPPER CHESAPEAKE 31. Date filed (Month, Day, Near) JAN 0 6 2010 32. Registrar's Signature State park Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** 2010 Mae Gutowski January 5:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1215 Roxboro Road Rosedale Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Apr 10, 1918 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F 220-48-3933 91 Maryland Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a, State show Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examinal must be notified at 1 ☐ Yes 24 ☐ No Director Md. Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filled within 72 hours after death with 1 nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 3 1215 Roxboro Road 21237 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🕅 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8th College (1-4or 5+) Laundry Operator Laundry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles McCord Minnie Weitzel ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1207 Roxboro Road Rosedale, Maryland 21237
ce of Disposition (Name of Lany Date v 20c. Location - City or Town, State Lillian Wohlfort/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) January Department of H Important: If Ite any Injury or ot once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cem. 8, 2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility aczorowski Funeral Home, P. A. 21. Signature of Funeral Service Licensee t 1201 Dundalk Avenue Baltimore, Md. Tola 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** B Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician: The law requires that the death certificate be executed physician and the burial-transit Hypritingion Due to (or as a consequence of) Box 68760; Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Year Month Dav 5 Other (specify) 1 ☐ Yes 2 🔀 No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 1 ☐ Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ⊟Yes 2 DNNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred or Attending 1X Natural 5 Pending s after death.
I Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 24276 January 4, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Simon V. Scalia, M.D. 2801 Hudson Street Baltimore, Md. 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year-Physician/ MonthanuaRey 121 9:26M GOLDSTEIN SIDNEY Medical 4c. County of Death Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Medical Cente Joseph 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Country) MD Days 1 🗶 M 2 🗆 F Hours Min. 05/25/1927 82 **Director** 217-24-8162 ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Tyes 2 No OWINGS MILLS MD BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2402 VELVET RIDGE DRIVE 21117 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, Give Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: "natural", 3 Widowed 4 Divorced WHITE Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important, If item 27 is marked other than "naturany Injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) OWNER TRU-FIT CLOTHES INC. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ HERMAN GOLDSTEIN SADIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLOTTE GOLDSTEIN / WIFE 2402 VELVET RIDGE DRIVE, OWINGS MILLS, MD 21117 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date ROSEDALE, MD 4 ☐ ¶onation 5 ☐ Other (Spec SHAAREI ZION CEMETERY 1/4/2010 re of Funeral Service Lic 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ ACUTE MYOCARDIAL INFARCTION Medical resulting in death) Due to (or as a consequence of): **Examiner** CARDIOMYOFATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year 5 Other (specify) 2 No ate has been signed by the page 2 should be detached 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn After this certificate Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred s after dea... al Director: After hy the fr Natural Accident 5 🗌 Pending injury 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide City or Town, State) Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 15452 40 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BESSENT. TIMOTHY 7601 OSLER DRIVE. TOWSON. MARYLAND M.D.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 JÄÑÜARY 6:34 AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 2502 SUMMERSON ROAD BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs, last birthday 8. Date of Birth 9. Birthplace (State or Foreign Country) MD Funeral 1 🗆 M 2 💢 F 0975571919 90 Director 220-01-6916 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a State 10h Counts 10d. Inside City Limits 10c. City. Town or Location Director 1 ☐ Yes 2 🏋 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2502 SUMMERSON ROAD 21209 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: "natural", Specify: 3 X Widowed 4 Divorced WHITE Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) LEGAL SECRETARY SOCIAL SECURITY ADMIN. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ KARPA ISRAEL NUMA GOLDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EILEEN LESSER / DAUGHTER 3304 TIMBERFIELD LANE, BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or of 1 ☐X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BOBROISKER BENEFICIAL 1/5/2010 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21, Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a consequence or) if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death this certificate has been signed by the are director, page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? the Hospital or Attending Physician; The I nin 24 hours after death. the Funeral Director; After this certificate h 2 No Yes 1 L Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 25 No 1 Tyes ည 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pendina 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Funeral Medical 29a. Certifier Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

on who completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ame ad item 200 per fiberalment of Health and Mental Hygiene

		1 - State Registrar	ame State of	Vlarylank		rement of			F	leg. No	010	00093
Physic /Med		1. Decedent's Name (First, Middle,	ICA F	4; 2		41- Oit- T-			2. Date of Dea Month	3 Day	2016	5 Pane or Death
Exam	iner	4a. Facility Name (If not institution, give street and number)  12408 Hall Shop Road				4b. City, Town,	or Location of Julton				inty of Death <b>Howard</b>	
Funera		5. Social Security Number 6	S. Sex 7	Age (In yrs. la		If Under 1 Year Months Days	If Under	24 Hrs. 8	B. Date of Birth (Month, Day			place (State or Foreign otry) ct of Columbia
Directo	r	577–01–9865 Usual Residence of Decedent	ILIWI ZIALF	94	Yrs.			D	ec. 2,	1915	Distri	ct of Columbia
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with th		10e. Street and Number	_			10f. Zip Code	20750			Ū	of What Cour	•
leath v	Funeral	12408 Hall Shop  11. Marital Status	12. Was Decede	nt Ever in U.S	6. 13. V	Vas Decedent of	20759 Hispanic Or	igin? (Spec	ify Yes or No-		States Race - Americ	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	Armed Force d 1 ☐ Yes 21 If Yes, Give Year or Date	<b>X</b> No		fYes, specify Cu □Yes 2127 No	ban, Mexicar	n, Puerto Ri	ican, etc.)		Black, White, on the second se	
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arylan, should be nd Mental marked c	10 B	Clarence Parke	er				Hele	n Mi	tche11			
C 0 2 0 2		19a, Informant's Name/Relationshi	p (Type. Print)			g Address (Stree						_
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ages ant of h	3	1 ☐ Burial 2 👿 Cremation 3		ite		sition (Name of natory or other pl	i	anuar -2000			•	aryland
Baltimore, permit. Pages 1 ar Department of Hea Important: If Item; any Injury or other	ا	4 □ Donation 5 □ Other (Special Signature of Funeral Service Li				natory, . Name and Add						yland, Inc.
any per Berry Barry Barr		Day als	Oler			9 Frede				-		•
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8760, cate be exployed the burial	dical Ex	resulting in death) Last	Due to (or	as a consequ	ence of);							
O. Box 6 he death certifi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ☐ Fetal nt at time of de	death 3 [	Ectopic pregnal Other (specify)				23d.	Date of delivened Month	ery Day Year
S, P.	by Pl	Part II. Other significant condition	s contributing to death	h but not resu	Iting in the ur	nderlying cause g	jiven in Part I	l.	23e. Did to	bacco use o	contribute to the	he cause of death?
cords, w requires t									1 🗆 Y	es 2□N	lo 3∏ Prob	Dably Unknown
Vital Records, stcian: The law requires to extrificate has been signe irector, page 2 should be	Completed								24a. Was a autop perfor 1 □ Yes		4b. Were auto prior to co death? 1 ∐Yes	psy findings available mpletion of cause of 2  No
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Of Phys er this	7:1	1 Yes 2 → No 27. Manner of veath	28a. Date of I	Injury	ER/Outpatier 28b. Time of	28c. ini	ury at		e Resid			(y)
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Division al or Attending s after death. II Director: After	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	Zoe, Place of	Injury - At ho etc. (Specify	me, farm, str	eet, factory, office		28	Bf. Location (S City or Tow	Street and No n, State)	umber or Rura	al Route Number,
Division of Vita io the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (		Physician: To the be xaminer: On the basi and manner	s of examinat								
To ti Withi To ti	Ň	29b. Signature and title of certifier	600	02		29c. Lice	se number	+70	Z (	29d. Date si	gned (Month,	Day, Year)
10		30. Name and address of person w	Proposition of the completed cause of	of death (Item	23a) (Type,	Print)	In So	3 /	LOGAR	0	2/2	09
S	tate	31. Date filed (Month, Day, Year)-	32. R/gi	istrar's Signat	ture	ale						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** HALL JANUARY MITRI 2010 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County/of Death Examiner HOSPITAL SE COURS BAITIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2□ F 217-82-759 ma. Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director ma Timore 28a-f 10e. Street and Number 2838 V 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ğ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite 1 ☐ Burial 2 remation 3 ☐ Removal from State 23a. P. M. Erfer the disease, or complications that caused the death. Do not enter the mod. If dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACMTE MYO CARRALL 4 ☐ Donation 5 ☐ Other (Specify) **Physician** ▶ /Medical Examiner Sequentially list conditions, tause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of burial-transit and Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed APNED OBSTRUCTIVE SLEEP 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed CARDIO MYOPATH 2 ☑No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1)3272 JANUARY 04

State Registrar 31. Date filed (Month, Day, Year)

AN 0.6 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



BON SECOURS HOSPITAL

State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OSEPH HARRISON 2010 02:55 AM anuary Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL of Baltimore Ballimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 X M 2 🗆 F Director 74 213-80-4283 Jamaica Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Meral Hygiene. Important: If tien 27 is an Meral Hygiene. Important: If tien 27 is and Meral other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No Baltimore, Maryland 21215-0036 Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 U.S.A. 4523 Pall Mall Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 X No Specify: If Yes Give Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Landscape Company 12th grade 6yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henrietta Wilks Alexander Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4523 Pall Mall Road, Baltimore, md 21215 Mertell Harrison-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) Memorial Park 1/16/10 Woodlawn, Md King gnature Fineral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onse and Death Ph<sub>sician</sub> disease or condition resulting in death) Medical Due to (or 's a consequence of): **Examiner** 50 years COPD Sequentially list conditions, if any, learning to transdictionate cause. Enter Underlying Cause (Disease or linjury Examine Directo for as a consection of or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 G Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial fibrilation TRVR 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 metastases this certificate has ral director, page 2 autopsy performed? Yes 2 No 2 No 1 Yes hours after death.

Ineral Director: After this certific
of filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No မှ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours To the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier Ceri D0068315 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, 6 2010 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:20 AM Medical County of Death **Examiner** Kilhurn Battimore landallstown 8. Date of Birth 9. Birthplace 7. Age (In yrs. (State or Foreign **Funeral** 1 M 2 D F Months Country) Director ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Kandallstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2113 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Seconday (0-College (1-4 or 5+) Doot of Juvenile Be 18. Mother's Name (First, Middle, Maiden Surname) မ 19b. Mailing Address (Street and Number or Rural R oute Number, City or Town, State, Zip Code) Randallstown Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ballimore, MD 4 Donation 5 Other (Specify) permit. Signature of Funeral Service Licenses ndalls to un, Mb 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or hear ure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Ph, sician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last april 6 9 Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown been signed by the a should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been six completed filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1. Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month. Day. Year) 2085 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's State JAN 0 6 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 730 DM 19 2010 Robert Davis Hamilton, Sr. 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Saltimore uare Jospital Center CosedaLe Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex If Under 1 8. Date of Birth Days Months **1**√2 M 2 □ F 06/20/1924 85 Pennsylvania 194 16 1648 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 1 Yes 2 No Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21205 USA 1111 Newcomb Way 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: 1942–45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel Mill 4 Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Esther Margaret Davis Kenneth Jaquette Hamilton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 25 Somerset Road Catonsville, Maryland 21228 Robert D. Hamliton II (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem Gardens 1/5/2010 Baltimore County Md. Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA uneral Service Licensee 1407 old Eastern Avenue Essex Maryland 21221 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death Part 1 Enter the disea shock, or heart failur Immediate Cause (Final Due to (r as a consequence of): disea a o condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cholangio carcinoma 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 ☑No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one)

9000 Franklin Square Drive Bullimone MD 2137

Box 68760 P.O. | Division of Vital Records,

Examiner requires that the death certificate be executed physician and s the burial-trans attending p s been signed by the should be detached aw 1 Jas page 2 certificate Physician: funeral director, this After t or Attending ours after death. neral Director: A filled in by the fu r death.

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

ð

Completed

**Funeral** 

Director

with

death v

72 hours after

d 2 should be filed within 72 th and Mental Hygiene. 7 Is marked other than "na

Department of Health a Important: If Item 27 Is any Injury or other trains

**Physician** 

/Medical

Examiner

Physician/Medical

à

Completed

Be

Certification: To

Medical

31. Date filed (Month)

Pages 1

Baltimore, Maryland 21215-0036

Hamilton

r is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at

within 24 hours a completely

examinery 1 ☐ Yes 2 ☐	No	Hospital	1 npatient 2	ER/Outpatient	3 □	DOA Other: 4 ☐ Nursir	ng Home 5 ☐ Re	sidence 6 Other (Specify)		
27. Manner of Death 1 Natural 2 □ Accident	h 5 Pending investigation		Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 □Yes 2 □ No	28d. Describ	e how injury occurred		
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e.	Place of injury - At h building, etc. (Speci	ome, farm, stree	t, facto	ory, office	office 28f. Location (Street and Number or Rural F City or Town, State)			
29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	iner: Or	To the best of my known the basis of examination manner stated.	owledge, death o ation and/or inve	ccurr	ed at the time, date and poon, in my opinion, death o	place, and due to the control occurred at the time	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)		
29b. Signature and	title of certifier	R.	RANGANA	TH -	2	Pec. License number	20	29d. Date signed (Month, Day, Year)		

MD

32. Refistrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

(angan ath

State

Registrar

DHMH 17 Rev 1/2001

10-00073	
Mary Alice	lacovella

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010

		1- For State Registrar		Cert	ificate o	f Death		Re	eg. No.	
Physici	an/	Decedent's Name (First, Midd			-			2. Date of Deat	th	3. Time of Death
Medical Exami	ner	Mary A. Ia  4a. Facility Name (if not instituti	covella	\	— т	4b. City, Town, c	r Location of De	Month January 3,	2010 4c. County of	1830 hrs
)		4905 Nantucket Road	t			College Pa	ark		Prince Ge	eorge's
Funeral Director		5. Social Security Number 578-36-6469	6. Sex 7. Ag	ge (In yrs. las		If Under 1 Ye  Months Da		1in.	`	Birthplace (State or Foreign Country)
		Usual Residence of Decedent	1M 2 - F	84	Yrs	5.		May 18	3, 1925	Maryland
w any		10a. State 10b. County		10c. City, T	own or Locat	tion				10d. Inside City Limits
ne Maryland or 28a-f show any fred at once,	tor	MD Princ	e George's	Coli	lege P	ark 10f. Zip Code	_	- 14/	og. Citizen of Wha	1 XYes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Director		ket Road			2074	0	"		at Country?
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shi trammatic event, the Medical Examiner must be notified at once		11. Marital Status	12. Was Decedent			s Decedent of H	ispanic Origin? (	Specify Yes or No-		American Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be	Funeral	1 Never Married 2 N	1 Yes 2	X No		es, specify Cuba		to Rican, etc.)	White, Specify: V	
urs afte tural",	d by	3 X Widowed 4 Div 15. Decedent's Education (Spe	vorced or Dates: ecify only highest grade cor	npleted) 1		Yes 2 X No		of work done	Specify: 16b. Kind of Busi	
6 72 hou in "nai	Completed	Elementary/Secondary (0-12)				ost of working life				,
within year that	duo	12th 17. Father's Name (First, Middle	ø		Н	omemaker			_	Home
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be C	Eugene Botel	•				Esther	ne (First, Middle, M Mae K		
212 ould b d Menis mari		19a. Informant's Name/Relations			19b. Mailing	g Address (Stre		r Rural Route Num		, State, Zip Code)
MD and 2 sho alth and om 27 is		Gisele P. Chef  20a. Method of Disposition	fi/Daughter	Took Die		2 Santa			rel, MD	20708
Baltimore, permit. Pages lar Department of Hee Important: If itei		1 X Burial 2 Cremation	n 3 Removal from St		ematory or ot	sition (Name of ce her place)	emetery,	Date	20c. Location - C	City or Town, State
Itim ii. Pag artment ortant:		4 Donation 5 Other S	pecify:	Fort	Linc	oln Ceme	tery 1/8	3/2010	Brentwo	ood, MD Home, P.A.
Dep Imp		Jamino 4	0 -14	M01103	3 3			nardson 1e, Laur		20707
Physician Medical		23a. P. T. I. Enter the disease, or failure. List only one cause	complications that caused on each line.	the death. D	o not enter t	he mode of dying	, such as cardiac	or respiratory arre	st, shock, or hear	t Approximate Interval Between Onset and
Examiner		Imme late Cause (Final disease or condition resulting in death)			of ri	ght hip	fracture	2		Death
		Sequentially list conditions,	Due to (or as a conset b.	equence or):						
	miner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of):						
T	Exam	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):						
760, icate be executed physician and the burial - transit		X UNPENDED	d							
'60, ate be e ohysiciar	Medical	IF FEMALE:	AMENDED 23a, PI	1,27,3	28a-f,	per ME, g	902 4/6	/10 TT	23d. Date of de	olivon
687(ertifica		23b. Was decedent pregnant in the past 12 months?	ne 1 Live birth	. 0	2 Fe	tal death 3	Ectopic pregi	nancy	Month	Day Year
Box 687: death certification at the attending of for use as t	ysician/	1 Yes 2 No 9 Uni		time of death	h 5 Ot	her (Specify)			1	
that the de led by the detached f		Part II. Other significant condit		but not resu	ulting in the u	inderlying cause	given in Part I.	23e. Did tot	pacco use contribu	ute to the cause of death?
S, P.O.  Lires that the signed by d be detac	ed be	Parkinson's	Disease; Chr	onic o	obstru	ctive pu	1monary	1 Yes	2 No 3	Probably 4 Unknown
cord: law request has been	Completed	disease						24a. Was a autops	y pri	ere autopsy findings available or to completion of cause of
tal Rec								perform 1 Yes 2		ath?  Yes 2 No
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	BB	25. Was case referred to medica examiner?	Hospital: 1 Inpatie	at 2 5	R/Outpatient		Other		Residence 6	011
of V ing Phys After thi uneral di	P.	1 Yes 2 No 27. Manner of Death	28a. Date of Inju (Month, Day,Y		8b. Time of I		ry at Work?		ow injury occurred	
ion tendin eath. for: A	Certification:	1 Natural 5 Pend 2 X Accident Inves			d 1805	hrs 1	Yes 2 No	subject	fell	
ivision At after dain by	ţįį	3 Suicide 6 Coul	d not be 28e. Place of In	jury - At hom	e, farm, stree	et, factory, office t	ouilding, etc.	28f. Location (St	treet and Number ate) 4905 N	or Rural Route Number, City antucket Road )
Ospital hours uneral		4 Homicide 29a, Certifier		eside					-	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only   Certifying Pi	hysician: To the best of my miner:On the basis of exar							
\$ 1 × 1 × 1	Me	29b. Signature and title of certifie	and manner stated.		_	29c. Licens	se number		29d. Date signed	(Month, Day, Year)
		MIC		> 1	1	) O.C.	M.E.		January 4, 2	010
Ø ./	Ī	30. Name and address of person Russell Alexander MD				Penn Street,	Baltimore N	/ID 21201		
St	ate	31. Date filed (Month, Day Year)	32 Registrar				Daidinole, N	712UT		
	Registrar JAN U 6 2010 Augus A. Janes									

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State Registrar Certificate of Death Reg. No. 2 1 1 1 1 1 1 1 9 9
	Physici	an	1. Decedent's Name (First, Middle, Last)  ANDREW E. JOHNSON  2. Date of Death Month Day Year 7:36 p M
-	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
			Anne Arundel Medical Center Annapolis Anne Arundel  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
l,	Funeral Director		5. Social Security Number 215—18—5007  Usual Residence of Decedent  6. Sex 120 M 2 F  7. Age (In yrs. last birthday) Yrs.  7. Age (In yrs. last birthday) Yrs.  86  Yrs.  7. Age (In yrs. last birthday) Yrs.  86  Yrs.  87  Yrs.  88  Yrs.  88  Yrs.  15 Under 17 ear   If Under 24 Hrs.   (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) Yes.  9. Birthplace (State or Foreign Country) Year   Month   (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) Year   Year   Year   (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) Yes.  9. Birthplace (State or Foreign Country)
	e Maryland 3a-f show tified at	ctor	10a. State Penncy I vania 10b. County Philadelphia 10c. City, Town or Location 10d. Inside City Limits 1 XXes 271No
	th with th 23a or 28 ust be no	al Dire	10e. Street and Number 15108 Milford Street 1511 Webster St. 10f. Zip Code 10g. Citizen of What Country? U.S.A.
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  14. Race - American Indian, Black, White, etc.  15. Yes 2 No Specify: White
21215-0036	in 72 hc n "natu hedicai	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired)
212	ed with ygiene. er thar t, the N	Com	12 College (1-4or 5+) Merchant Marine Exxon
and	d be file ental Hy ced oth	Be	17. Father's Name (First, Middle, Last)  Warren L. Johnson  18. Mother's Name (First, Middle, Maiden Surname)  Lola Persons
aryl	and Me	2	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
e, ≥	s 1 and 2. of Health a ifem 27 is other trau		Bernard Johnson (Nephew) 15108 Milford Street, Philadelphia, Pennsylvania 19116  20a. Method of Disposition Date 20c. Location - City or Town, State
Baltimore, Maryland	Pages ment of h ant: If ite		1/2 Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 01-06-2010 Baltimore, Maryland
Balt	permit. Depart Import any Inj		21. Signature of Foreral Service License 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A.  130 East Fort Avenue, Baltimore, Maryland 21230
	Physician /Medical Examiner		23a Faft1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.  In mediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Approximate Interval Between Onset and Death
i i		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
ь.	xecuted and al-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):
68760,	ificate be executed g physician and as the burial-transit	edical E	d.
O. Box	death certif e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
S, D	The law requires that the te has been signed by the hage 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes   2   2   3   Probably   4   Unknown
Division or Vital Record	sician: The law re certificate has be rector, page 2 sho	Completed	24a. Was an autopsy performed performed 1 ☐ Yes ☐ No 1 ☐ Yes 2 ☐ No
Ĭ.	s certifi	o Be	25. Was case referred to medical examiner?  1  Yes 2  No
n or	Attending Physician: r death. ector: After this certific. by the funeral director, I	-	27. Manner of Death 1 Setural 5 Pending (Month, Day Year) 28b. Time of Injury 28b. Time of Injury Work? 28c. Injury at Work?
Divisio	5 <del>2</del> <del>2</del> <del>5</del> <del>5</del>	Certification:	Accident investigation    Accident investigation   Investigation   Investigation
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical C	29a. Certifier  (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the within To the compl-	Me	29b. Signature and tille of cattifier 29c. License number 29d. Date signed (Month, Day, Year)
)		-	30. Name and address of Jerson who completed cause of death (Item 23a) (Type, Rint) David Drive Cherle M 2/6/5
			30. Name and address of Jerson who completed cause of death (Item 23a) (Type, Rint) Dared Drive Cherle M) 2/6/9
	Sta Registr	_	31. Date filed (Month, Day, Year)  32. Registrar's Signature  32. Registrar's Signature

			Plea	se Type or Pri						-			le.		
			for State Registrar	State of M	aryland /		artment of F <i>rtificate of</i>		na Me	•	giene Reg. No.	201	0	0.0	100
			1. Decedent's Name (First, Middle	e, Last)					2	2. Date of De				3. Time of	of Death
	Physici		Kenneth Earl	Keller						Month /	Day 5	20	ear 10	61	OAM
the age	/Medic Examir		4a. Facility Name (If not institution	n, give street and number,			4b. City, Town, o	r Location of	Death	-	4c.	County of			
. January .	LXdiiii		FRANKLIN SO	quare Hose	ital		205	eda	10			Bal	Tir	nore	100
	Funeral		5. Social Security Number	6. Sex 7. Ag	je (In yrs. last b	oirthday)	If Under 1 Year	If Under 24		Date of Bir	th Your			lace (State	
	Director		385-48-1740	1 🔀 M 2 🗆 F	62	Yrs.	Months Days	Hours	Min.	Date of Bir (Month, Da 09/01/	1947	J	Cenn	essee	
	pr ,		Usual Residence of Decedent											0.1 1	20.00
	arylar show	~	10a. State 10b. County		10c. City, To	wn or Lo .timo							1,	0d. Inside (	s 2⊟No
	8a-f	Directo	Maryland		Dai	CIIIC									, 2010
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show detai Examiner must be notified at		10e. Street and Number				10f. Zip Code	_				zen of Wh		try?	
	ath v	Funeral	1057 Bunbury Way	•			2120					.S.A.			
	er de	n n	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of H If Yes, specify Cub	lispanic Origi an, Mexican, I	in? (Speci Puerto Ri	ify Yes or No can, etc.)	)-	<ol> <li>Race - Black,</li> </ol>	· Americ White, e		
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7	with jene. <b>tha</b>	E	Elementary/Secondary (0-12)	College (1-4or		bore	er				Shi	ppind	ī		
D	filed I Hyg other ent,	Be C	17. Father's Name (First, Middle,	Last)	,,			18. Mother's	s Name (/	First, Middle,					
lan	ld be lental ked if ev	To B	Carl Keller, Sr	•				Sally	Thor	mpson					
ary	shou nd N mar	-	19a. Informant's Name/Relations		19	b. Maili	ng Address (Street	and Number	or Rural F	Route Numb	er, City o	r Town, Si	tate, Zip	Code)	
ž	nd 2 alth a 27 is r trai		Shirley Cassidy	(ex-wife)	1	O Wa	arren Cre	scent,	Dub.	lin 15	, Ir	eland	Ē		
ē,	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumarts event, the Medical Examinar must be notified at		20a. Method of Disposition		20b. Place	of Dispo	osition (Name of matory or other place	co)	Dat	te	20c. Lo	cation - Ci	ity or To	wn, State	
Ē	Page rent c nt: If		1 ☐ Burial 2 【XCremation 4 ☐ Donation 5 ☐ Other (S		t t		Crematory		1/06	/2010	Balt	imore	a. M	arvla	nd
Baltimore, Maryland	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Euneral Service		Dayvi		2. Name and Addre								
ñ	permil Depar Impor any ir once.		1				1407 old	Tactor	n Aw	enne enne	EGGE II NO	me, i	arvl	and 2	1221
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that cause	the death. Do							A PIL	AL Y	Approxima Interval Be	ate
	Physician	à ii	Immedia Cause (Final	only one cause on each li	ofib									Onset and	
}	/Medical		disease or condition resuling in death)	a. Due o (or as	a consequence		212						_		
-	Examiner			200 10 (0) 40	a consoquence	0 01).									
		ē	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b Due to (or as	a consequence	e of):									-
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	•											
Ċ,	be executed ician and ourial-transit	Exa	resulting in death) Last	Due to (or as	a consequence	e of):									
68760,	rificate be executed og physician and as the burial-transit	ca		d											
68	Attending Physician: The law requires that the death certificate r death.  sctor: After this certificate has been signed by the attending physiby the funeral director, page 2 should be detached for use as the the funeral director.	Physician/Medical													
Box	eath cer attendin for use	Ş	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		+h 2.[	Testonio prognano	74.6			2	23d. Date	of delive	ery	
 	deat e atte	icia	in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth			☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	<i>у</i>				Mont	h	Day	Year
P.O.	that the de ned by the	hys	9 ☐ Unknown	9 🗆 Unknown											
'n.	es tha igned be def	by P	Part II. Other significant condition	ons contributing to death b	ut not resulting	in the u	nderlying cause giv	en in Part I.		23e. Did t	obacco u	se contrib	ute to th	ne cause of	death?
ğ	w require been signature should b	ed								1 🗆 '	Yes 2	□ No 3	☐ Prob	ably 4	tonknown
သို	law re as bei 2 sho	Completed								24a. Was				psy finding	
æ	The law cate has page 2 s	E			-						psy rmed? 2 100	de	ath?	mpletion of 2  No	cause of
Vital Records,	fcian: The certificate ector, pag	e e	25. Was case referred to medical					26. Place o	of Death (	│ 1 □ Yes 'Check only o	-	'L	1168	2 🗆 140	
<u> </u>	ding Physici T. After this cer funeral direct	0 0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpati	ent 2 ER/C	Outpatie	nt 3 DOA Oth	or.		e 5∐ Resi		G □Other	(Specif	v)	
ı of	g Physical this leral di	Ë	27. Manner of Death	28a. Date of Inj	ırv 28b.	. Time o				d. Describe				,,	
Division	ttending I death. stor: After / the funer	atio	1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investi		iy, reary	injui y		N: ]Yes 2 □ No	0						
Vis	Atte	iji	3 ☐ Suicide 6 ☐ Could determ	inod   26e. Place of In	ury - At home, t	farm, str	eet, factory, office		28	f. Location (			or Rura	l Route Nu	mber,
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	ospit hour unera			ng Physician: To the best Examiner: On the basis											(e)
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one)	and manner st		and/01 II		opinion, dean		at the time,	uate and	piace, an		nie cause	(5)
	vith vith com	Σ	29b. Signature and title of certifie	r	GUTEN	BII	VH 29c. Licens				29d. Dat	te signed (	Month,	Day, Year)	
			1 DWC	111		, -	065	5094	1_			1-5	-10	)	
			30. Name and address of person												
			DR BINH NGU	Jen gope	FRAN	KLIL	1 Squar	e DR	- Bo	xLTO	mo	1 2	123	7	
	Sta		31. Date filed (Month, Pay, Year	2010 32. Aegist	ar's Signature	La	all								
1	Registr	ar	#/// U	2010	- P.	7	****		<del></del>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ rlino 6:35 PM 2010 Medical Examiner 4a. Facility Name (if not institution, give street and humber) 4b. City, Town, or Location of Death 4c. County of Death OSpice baltimore nan baltmore St . Social Security Numbe 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Months Min 1 🗆 M 2 🗹 Month, Day, Year 1955 213-80-1130 Yrs **Director** 28a-f show 10a, State 10b. County ral", or items 23a or 28a-f shor Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No WD Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral Winner 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 2 No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BACK 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Lyears Be 18. Mother's Name (First, Middle, Maiden Surname ပ nber or Rural Route Number, City or Town, State, Zip Code)
NEWAY Randallstown, wp 21133 19b. Mailing Address (Street 9950 Shoshone Way Clarke-Block Danah 20a. Method of Disposition 20b. Place of Disposition (Name of ery, crematory or other place) Burial 2 Cremation 3 Removal from State Woodlawn, MD DOID 4 Donation 5 Other (Specify) 22. Name and Address of Facility Voughn C. Greene funeral SWS. Signature of Funeral Service Licenses Randallstown, ND 21133 23a, Part 1, Enter the dis ase, or complications that caused the death. Do not enter the mode of dying, such as a List only one cause on each line. shock, or hear Interval Between Onset and Death Immediate Cause (Fina (olun Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and s the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant Box ( 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year Pregnant at time of death Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 🖟 o 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Jas autopsy performed? Yes 2 N 2 No 1 Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis or examination arrover investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D68286 Jan 3, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St. E 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician 7:10 P M January 2010 Sheckells Mosner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Baltimore Timonium 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 82 Days Hours 1 □ M 2 🔀 F 212-24-0789 Director 11/26/1927 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "network". 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b, County 1 ☐ Yes 2 X No Funeral Director Timorium MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2300 Dulaney Valley Road 21043 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 7:10~P.M. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: White Completed by 3 ☐ Widowed 4 🔀 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sheckells Hazel Robert 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Thomas / Daughter 111 Burke Ave., Towson, MD 21286 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 1/5/2010 Hanover, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P., Hanover, MD 21076 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): JANUARY 1, 201. To the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Mnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 1 ☐ Yes 2 Deto 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Matural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintened as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M20) JANUARY 4, 2010

State Registrar

MOSNER

2300 DULANEY VALLEY ROAD

32. Registrar's Signature

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

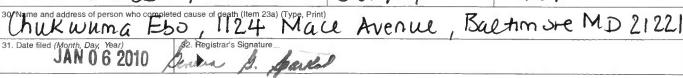
EDDIE NAKHUDA, M.D.

31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) **JAN 0 6 2010** 



**ORIGINAL** 

			Please 7 Amend 19a, per Inf	ype or Print	t in Bla	ck In	ndelible In	k. Ens	sure All C	opies A	Are Legible		
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` · · · · · ·	Funeral		8567 Chris Cour 5. Social Security Number 6. Sex	7. Age (II	n yrs. last b	irthday)	9. Bi	e Arundel  thplace (State or Foreign					
	Director		164-22-6088	M 2 🗆 F	79	Yrs.	Months Days	,1930 Pe	nnsylvania				
	and show 1 at	tor	Usual Residence of Decedent  10a. State 10b. County	10	0c. City, To	wn or Loc	cation					10d. Inside City Limits	
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	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at		10e. Street and Number 8567 Chris Court				10f. Zip Code 21122	)		10g	10g. Citizen of What Country? U.S.A.		
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36	after d I", or i xamin	by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give	)	- 1	Yes 2 X No		etc.)	Black, Whit			
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Maryland	should be file n and Mental F is marked o raumatic eve		19a. Informant's Name/Relationship (Type				•			, ,	ty or Town, State, Z	,	
è,	and 2 Health tem 2		Ruth I. Black (Wife 20a. Method of Disposition	<u> </u>			sition (Name of	urt	Pasadena Date		yland 211		
mo	Page 1 nent of int: If i		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		cemet	tery, crem	en Mem. F	1			•	e, Maryland	
Baltimore,	permit. Page 1 and 2 st Department of Health a Important. If item 27 is any injury or other tra once.	8	21. Signature of Funeral Service Licensee		01011						me, P.A. , Marylan		
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	กงจ <del>่งเล</del> ก/		shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	' (		V 2	- 1	n L.			Approximate Interval Between Onset and Death	
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ds, I	v requires the been signer should be	ed b	Lung Cance	4						1 🗆 Yes	2 □ No 3 □ F	Probably 4 ☐ Unknown	
of Vital Records,	law rec has bee ge 2 sho	Completed by	Atrial Fib	Villation	1				24	4a. Was an autopsy	prior to	ntopsy findings available completion of cause of	
Re	ician: The la certificate ha rector, page		25. Was case referred to medical							performed ☐ Yes 2 2	d? death? No 1 ☐ Ye	s 2 No	
Vita		To Be	examiner?	spital:	2 □ FB/0	Outpatien	Othe		ath (Check only o		e 6 🗀 Other (Spec	5164	
of	Attending Physician: r death. ector: After this certific by the funeral director,		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Ye	28b.	. Time of injury	28c. Injury	/ at			njury occurred	anyy .	
sion	uttendi death ctor: A y the fu	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	. At home if	farm etra		Yes 2		action (Ctross	tand Northern an D	m I Drude Museban	
Division	al or A s after il Direc ed in by	Cer	4 ☐ Homicide determined	building, etc. (S		iam, sire	et, factory, office			by or Town, Si	t and Number or Ru tate)	rai Houte Number,	
_	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical	29a. Certifier 1 Certifying Physici (Check 2 Medical Examine	r: On the basis of exam	nination and	/or investi	igation, in my opinic	n, death o	occurred at the tim	e, date and pl	lace, and due to the	cause(s) and manner stated.	
	o the l	Me	only one) 3 Certifying Nurse I  29b. Signature and title of certifier	Practioner: To the bes	st of my know	wledge, d	leath occurred at the	e time, dat	e and place, and o	due to the cau	use(s) and manner as  Datte signed (Monta	stated.	
			> A Enlle	>-	MD		D	So	470	1	5/20		
			30. Name and address of person who com	Pleted cause of death	h (Item 23a)	(Type, Pi	rint) Trashway	Suit	1800, (	Glen	Burnie	MD21061	
	Stat Registra	te ar	31. Date filed (Month, Day, Year) JAN 06 2010	32. Registrar's	ignature	arke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State C	of Maryland / Depa	artment of Hortificate of D		al Hygiene,	2010 0010
Physici /Medic		1. Decedent's Name (First, Middle, Last)			M	ate of Death Ionth Day	Year 902 PM
Funeral	er	4a. Facility Name (If not institution, give street and not North Hours + Hospital)  5. Social Security Number  218-70-9096  6. Sex	7. Age (In yrs. last birthday)	Ab. City, Town, or I	SFOUN If Under 24 Hrs. 8. D. Hours Min. (A	ate of Birth	County of Death  1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Director 4 show	tor	Usual Residence of Decedent  10a. State	48 Yrs.  10c. City, Town or Lo		F6	eb. 13,19	61   PA 10d. Inside City Limits 1 □ Yes 2,⊒No
Description is invarigating Z IZ 13-0030  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highly or other traumatic event, in Modeal Examinar i and to notified at once.	Completed by Funeral Director	10e. Street and Number  2126 Carroll Dale Road  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)	edent Ever in U.S. 13. Troces?  **XX**No live values:	10f. Zip Code  217  Was Decedent of His If Yes, specify Cuban 1 □ Yes 2 ☒ No  dent's Usual Occupa	spanic Origin? (Specify Y n, Mexican, Puerto Rican Specify: tion uring most of working	Yes or No- (, etc.)	ited States 4. Race - American Indian, Black, White, etc.  Specify: White d of Business/Industry
Mal y latin Z L Z I	To Be Com	Elementary/Secondary (0-12) College ( 12th  17. Father's Name (First, Middle, Last)  Harry Alwin Nevel	7	/P	18. Mother's Name <i>(Firs</i> Barbara		,
Pages 1 and 2 shonent of Health and int: If item 27 is many or other traum		19a. Informant's Name/Relationship (Type. Print)  Barbara Nevel Mother  20a. Method of Disposition  1□ Burial 2 ☑ cremation 3 □ Removal from	2126  20b. Place of Dispo	Carroll  sition (Name of natory or other place	) Date	Sykesvil 20c. Loc	le, MD 21784 ration - City or Town, State
permit. Pages 1 ar Department of Hea Important: If Item: any Injury or other once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licenses	South Car	Name and Address	of Facility		Sykesville, MD Crematory, PA esville, MD 21784
Physician /Medical Examiner physician and the prival-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin. Cause (Disease or injury that initiated events	cor as a consequence of):  (or as a consequence of):	er the mode of dying	, such as cardiac or res	pliatory arrest,	Approximate Interval Between Onset and Death
ath certifications is or use as	Physician/Medical	in the past 12 months?	nant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		2	3d. Date of delivery Month Day Year
w requires that the de s been signed by the a should be detached to	þ	Part II. Other significant conditions contributing to d	leath but not resulting in the u	nderlying cause giver		1 ☐ Yes 2 ☐	se contribute to the cause of death?
Physician: The law requires the rithic certificate has been signed in director, page 2 should be contacted.	e Completed	25. Was case referred to medical				24a. Was an autopsy performed?  Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 700
ding Afte fune	Certification; To B	27. Manner of Death  1 Natural 5 Pending investigation  2 Accident investigation  3 Suicide 6 Could not be determined 28e. Place	Inpatient 2 ER/Outpatier of Injury tith, Day, Year) 28b. Time of Injury a of Injury - At home, farm, str ing, etc. (Specify)	ont 3 DOA Other  f 28c. Injury Work?  M 1 Y	□Other (Specify) occurred  Number or Rural Route Number,		
To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the land man	e best of my knowledge, deat pasis of examination and/or in iner stated.	h occurred at the tim vestigation, in my op	e, date and place, and d inion, death occurred at	ue to the cause(s) the time, date and	and manner as stated. place, and due to the cause(s)
To the Within Comp.	Ž	29b. Signature and fille of certifier		29c. License	e signed (Month, Day, Year)		
Sta Registr		30. Name and address of person who completed cau  Tany eer (2015, 5401 01)  31. Date filed (Month, Day, Year)  JANOS 2010			UN MD ZII	33	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ РМ Laura M. Philbrick January 2010 9:28 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 719 Maiden Choice Lane, Baltimore Catonsville BR. Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 6. Sex 1 □ M 2 🛛 F Months Hours Min. 5/19/1923 220-30-2500 86 Director Missouri Usual Residence of Decedent 28a-f shov 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Baltimore Catonsville 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21228 USA 719 Maiden CHoice Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. "natural", or þ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Health Care Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Forbis Samuel Phibrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 915 Saxon Hill Drive, Cockeysville, MD 21030 Paul Cvach / Personal Rep 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/11/2010 Glen Haven Mem. Pk. Glen Burnie, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Si nature of Funeral Service Licensee 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Cauces Sequentially list conditions, if any, leading to improve the if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? for Month Day Year the 9 Unknown 9 Unknown n signed by t. Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? After this certificate 1 🗌 Yes 2 🗌 No 2 - No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending death. 1 Yes 2 No Investigation 6 Could not be Accident after death 3 
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catensville, MA RU Mp 31, Date filed (Month, Day, Year) Registrar's Signatu State

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State of Maryland / Department of Health and Mental Hygiene certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 3 rel Month Physician/ Pettil Ruth 10-130 P M tanua 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Sonai Hospital of Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 2 08 34 Hours 1 □ M 2**X**□ F 75 Director 217-34-4819 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Owings Mills 1 Tes 2 XNo Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21117 8110 Green Valley Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12)
12th grade College (1-4 or 5+) na St. Paul School Cook Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Francis Fleming Morris Milburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 Owings Mills, De Borah Gaines-Daughter 8110 Green Valley Lane, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/9/10 Baltimore, Md Loudon Park 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Signature of Juneral Service Licensee Baltimore, Md Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Intracraneal 10 day Medical Due to (or as a consequence of): Examiner Sequentially list conditions, CERTIFICATION APPROVISED BY MEDICAL EXAMINER if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Diabeles page 2 should Lypertonsion 24a. Was an Were autopsy findings available prior to completion of cause of certificate has autopsy death? Yes 2 N 1 Yes Division of Vital 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 X Yes 2 1010 ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this ne Hospital or Attending Phor 24 hours after death.

Refuneral Director: After the 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Watural 5 Pending 2 Accident Investigation Suicide 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D0068315 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 244/ W Belvedere Ave. Baltimore. M. 3/12/5 Baltimore, Hospital of Sinai cu! 31. Date filed (Month, Day, Year)

JAN 0 6 2010 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Vivian May Pohl January 4, 2010 1414 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Harford Memorial Hospital Havre de Grace If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 05/21/1927 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Davs Hours 1 ☐ M 2 TIE Yrs. 220-20-2224 82 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b, County Maryland Baltimore Essex 1 ☐ Yes 2XNo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21221 U.S.A 1000 Franklin Avenue, Apt. 303 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2XXNo Specify: Specify: 3XXWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembler Electronics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Kuhn Pearl Phillips 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) Gail Forster (Daughter) 650 Branda Lane, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State Dulaney Valley Mem. 01/08/2010 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A. Signature of Funeral Service License 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Epfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiogenic disease or condition resulting in death) Due to (or as a consequence 1/1) locardia Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last but to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛱 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

Examiner death certificate be executed burial-transi the attending pl for use Ö Records, Hospital or Attending Physician: The Division of Vital

Physician/Medical Examine Be Completed by Medical Certification: To

תושו uns certificate has been signed funeral director, page 2 should be det 24 hours after deatl Funeral Director: filled in by the

**Physician** 

/Medical

Director

Funeral

Be Completed by

ဂ္

Examiner

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "locical Examiner must be retified at

death with the Maryland

filed within 72 hours after

atth and Mental Hy.

of L

Department of Important: If it any injury or o once.

**Physician** 

/Medical

Pages 1 and 2 should

Baltimore, Maryland 21215-0036

3 Suicide 4 Homicide 29a. Certifier (Check only one)

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature 31. Date filed (Month, Day, JAN 6

State Registrar

completely

within 2.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year 910 ДМ CON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimare 05 Baltimore City Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 4/18/19) Birthplace (State or Foreign Country) **Funeral** Min 1 X M 2 □ F Director Yrs 85 219-18-8370 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Completed by Funeral Director 1 Yes 2 No Maryland Anne Arundel Glen Burnie 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 803 Bentwillow Dr. 21061 United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces' Black, White, etc. 1 Never Married 2 Married XXYes Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 ☑ Widowed 4 ☐ Divorced Specify: Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Aviation Machinist US Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Department of Health and Ment.
Important: If item 27 is marked
any injury or other treesons. Peter Przylepa Sophia Kufel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> John Przylepa / Brother</u> Greenwood Ave. Glen Burnie, MD 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Meadowridge Mem. Park 1/7/2010 Elkridge, Maryland e eLService Lice 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy. SE: Glen Burnie, MD 1013 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute infatotia disease or condition Medical resulting in death) Examiner The lose lera Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exam ending physician and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Pregnant at time of death 2 No been signed by the s should be detached 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has al director, page 2 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ဂ္ဂ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of nours after death.

neral Director: After the filled in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tyes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined within 24 hours a the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 751C 50 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-1-velman Michael 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 20b, c per fh 8899 1-20-10
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Kogers sernan AM :10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town **Examiner** or Location of Death 4c. County of Death Bultimare const timore 9. Birthplace (State or Foreign Country)
New York 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth **Funeral** Year) 3.1<u>932</u> 1 □ M 2 □ F Months Days Min (Month, Day, Ye Feb. 28 **Director** 082-26-0565 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Marktal Hygiene.
Important: If item 23a or 28a-f sho amplicative in the Maryland Property and Wedley and Wedley and Maryland Property and Wedley Application and Wedley and Maryland Property of the Traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Woodside NewYork Queens 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 50-23 45th Street Apt.3F 11377 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White Completed ¾☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Port Authority of Secretary 12 York & New Jersey Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Eleford John McKeon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 1 3 7 7 50-23 45th Street, Apt. 3F, Woodside, New York Charles Rogers/Son Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State **Hawthorne** 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gafe of Heaven Salvary Cemetery 1-8-10 Woodside, New York . Signature of Funeral Service Licens 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. chall 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final ns t and Death Physician/ breast disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician by Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 ponths? 23d. Date of delivery 3 Ectopic pregnancy for Month Dav Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ j 9 ☐ Unknown detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be )Stconewosis 2 No Completed 1 Yes 3 Probably 4 Unknown peen Hupertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an **To the Funeral Director:** After this certificate has t completed filled in by the funeral director, page 2 s autopsy performer Yes 2, 2 Diabetes Mellitus 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence Hospital: ြု 1 Inpatient 2 ER/Outpatient 3 IDOA 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural injury 5 Pending 2 Accident Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 68286 Jan 3. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

701

harles St

Baltimure, MD 21204

			_ For	State of M						-		_	e.	
			State Registrar	41		Cer	tificate	of E	Death		Reg. N	10.20	0.	00111
	Physicia Medic		KATHENINE E. STUNKAND					2. Date of Death  Month  D  JAN  5						3. Time of beath 12:50P M
4	Examir	er	4a. Facility Name (if not institution, gi STELLA MARIS HOS	SPICE				Town, or MONI	or Location of Death			4c. County of Death BALTIMORE		
	Funeral Director		5. Social Security Number 6. 220~05~7027	_ V_   " ' '   "   <del>                                </del>								g. ε	9. Birthplace (State or Foreign Country) Maryland	
	land show dat	tor	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo							10d	. Inside City Limits
	the Mary or 28a-1 e notifie	Funeral Director	Maryland Baltimo  10e. Street and Number	re City		В	altim   10f.Zip		City		10a. C	citizen of What	Country	1 🔀 Yes 2 🗌 No
	h with ns 23a nust b	nera	5709 Benton Heig	hts Avenue				2	1206			USA		
9800	s filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3(☐) Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Yes XX If Yes, Give Year or Dates.		l'	Vas Deced f Yes, speci	ify Cuba	n, Mexican, Pue	Specify Yes or No rto Rican, etc.)	-	14. Race - Ar Black, WI Specify: WH:	nite etc	
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and	be filec ental H ked otl c even	To Be	17. Father's Name (First, Middle, Last John H. Trautfel							s Name (First, Middle, Maiden Surnam garet Buedel			me)	
Maryland 21215-0036	of Health and Mental File of Health and Mental Fitem 27 is marked of rother traumatic ever		19a. Informant's Name/Relationship Evelyn Loncar (D	Type, Print)		1			nd Number or F	Rural Route Numb	er, City o	or Town, State,	Zip Coc	le)
ore,	of Hea of Hea fitem rother		20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3		20b. P	lace of Dispo	sition (Nam	ne of	-	Date Date	_	Location - City	or Town	, State
Baltimore,	permit. Page 1 and 2 sh Department of Health an Important; If item 27 is any injury or other trau		4 Donation 5 Other (Spec	cify)		idon Pk	. Cem	nete	ry 1-8	3~2010		ltimore		d.
Ba	perm Depa Impo any ii		21. Signature of Funeral Service Lice	sahn		22   	. Name and .assah	Addres	s of Facility Uneral H	dome 74		Belair Rd. imore, Md. 21236		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. CHRONIC OBSTRUCTIVE PULMONARY  Due to (or as a consequence of):  Sequentially list conditions, if the product of the cause. Enter Underlying										rrest,		In	oproximate terval Between nset and Death
09,	ate be executed bhysician and the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	a consequ	ence of):								
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	by Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗶 No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 🗀 Feta	Ideath 3 □	Ectopic p		/			23d. Date of o	delivery Da	y Year
ls, P.O.	uires that t n signed b ıld be deta		Part II. Other significant conditions	contributing to death b	ut not resi	ulting in the u	nderlying ca	ause giv	en in Part I.		tobacco Yes 2	use contribute	to the c	
Division of Vital Records,	he law req ite has bee age 2 shor	Completed							-	24a. Was auto perfe 1 \(\sum \) Yes	psy ormed?	prior to death?	o compl	findings available etion of cause of
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of Vi	Physir this o	유	1 Yes 2 <b>X</b> No 27. Manner of Death	1 Inpation		ER/Outpatien 28b. Time of			4 LI Nursing	Home 5 Resi			ecify)	HOSPICE
ou c	ading ath. rr. After	icate	1 X Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	(Month, Day		injury	M	c. Injury work?	res 2 No	28d. Describe	now inju	ry occurred		
Divisi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	el Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	office		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	e Hospi 24 hou e Funer eleted fill	Medical	(Check 2 L Medical Exar	ysician: To the best of niner: On the basis of ex rse Practioner: To the	kamination	and/or investi	gation, in m	ny opinion	<ol> <li>death occurred</li> </ol>	at the time, date	and place	e, and due to the	e cause/	s) and manner stated.
	To th withir To th comp		29b. Signature and title of certifier	1.10				License		naos, and duo to t		ate signed Mor		
			30. Name and address of person who	Completed cause of de	eath (Item	23a) (Type D	int)	140	1192	_		115/2	DI	)
1			JACKIE JONES, C	RNP 2300 1	DULAN	EY VAL	,	D.	TIMONIU	JM, MD 2	1093			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 6.35AM STANTON ENTIN 2010 JAN /Medical 4c. County of Death 4b. City, Town, or Location of Death cility Name (If not institution, give street and number) Examiner atonsville Baitemore taven NUrsing Home If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, 03 18 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** 217.52.7877 1 M 2 □ F MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be marked. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Baltimore 1 Yes 2 No MD Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Boulevard USA 3100 Garrison . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1 Never Married 2 ☐ Married Specify: BOCK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12th Orade Analust 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Idella ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltinone MD 21216 Sister 3100 Garrison Bowland Barbara 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □Removal from State Guynn Dak, MD orraine Park O 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses sugher C. Greene. Funeral Sts 22. Name and Address of Facility 8 Road Kandallstown MD 21133 ibertu 23a. Part1. Enter the elsease, or complications that caused the death. Do not enter the mode of dying, such as rollar or respiratory arrest shock, or heat elliure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ANCER **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 DUnknown 2 🗌 No 3 Probably 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2. neral director, 25. Was case referred to medical examiner? 26. Place o eath Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending investigation in 24 hours after the Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) within 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith avE, SUITE 283, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Stevenson AM 1:15 /Medical cility Name (If not institution give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death taltimore Nursing 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1**▼**M 2□ F Hours Min Director Usual Residence of Decedent 10b. County 10c. City, Town or Location show 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be rufflied at Director Baltimore 1 Yes 2 □ No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21206 USA items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 🛮 No Specify Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Father's Name (First, Middle, Last) or Rujal Route Number Important: If item 27 uster 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Methed of Disposition Pages Department of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 10 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 Unknown is certificate has been signed director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate 2 **□**No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2  $\square$  No within 24 hours after death To the Funeral Director: filled in by the 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) valtram Woods man 88 32. Registrar's Signature 31. Date filed (Month) Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 12:19 PM Swanson 2010 anuar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospita Harbor Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F Days Hours Min. Director 88 228-16-7742 5-18-1921 VIRGINIA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show 10d. Inside City Limits Director N/A 1 X Yes 2 ☐ No MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 407 ROUNDVIEW RD. USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔲 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) TRUCK DRIVER SEALTEST DARIES Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN Be Pages 1 and 2 should be nent of Health and Mental 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1909 CHEYNNE TRAIL JONESBORO. JOHN SWANSON. JR(SON) GEORGIA 30236 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 D Burial 2 Crema 3 Removal from State ARBUTUS MEMORIAL PARK 1-11-2010 BALTIMORE, MARYLAND 5 ☐ Other (Specify) 4 Donation 21. Signature PLICENSE JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Par 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest s'o,x, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme is e Cause (Final disease or condition resulting in death) **Physician** Due t (r as a consequence of): /Medical Examiner Due (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Hypothyroidism Due to (or as a consequence of): and burial-tra Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 □ Yes 1 ☐ Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 X ER/Outpatient 3 □ DOA After this 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 No within 24 hours after deati 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certific

30 31. Date filed (Month, Day, Year)

JAN06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

South

3001

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Januar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 0744 AM MaryEllen M. Shepherd Januar 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 6. Sex Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2**X** F Months Days Hours Min (Month, Day, Year) Director 212-26-2765 82 uly15, Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits or 28a-f Del<u>aware</u> Sussex Selbyville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 37723 North Shady Drive 19975 S.A. death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. or 1 Never Married 2 Married Yes 2 No 72 hours after Completed by Baltimore, Maryland 21215-0036 If Yes. Give 1 ☐ Yes 2X No Specify: "natural", 3 √Widowed 4 □ Divorced Specify: White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Banking <u>Supervisor</u> Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles E. Bogy Edna Wetters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Warren K. Shepherd/Son 1617Hancock Ave., Appollo, Pennsylvania 15613 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 1 - 6 - 104 Donation 5 Other (Specify) rdentCremationServices Ha<u>nover,Maryland</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel 27274 Road, Baltimore, Maryland 21274 muhael 6009Harford 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ infarction Myocardial Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed burial-transi ardiogenic and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ó Pregnant at time of death Day Year pec ed by the signed by the Part II. **Other** si**gnificant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred Natural 5 Pending injury s after death. 1 ☐ Yes 2 ☐ No Accident the Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State within 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and tit 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) U hion

DHMH 17 Rev 7/2009

State Registrar Date filed (Month)

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) VANUARY 1:10 P-M Physician 2090 SURASKY NATHAN В /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DEEIL PERRY POINT HEALTH EARE SYSTEM If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Date of Birth (Month, Day, Year) 10/31/1941 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 217-38-9475 68 Yrs. MD Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland featth and Mental Hygiene. 10d. Inside City Limits 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f show 1 X Yes 2 □ No Directo N/A BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 215 BOLTON PLACE 21217 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) COMMERCIAL MORTGAGE BROKER FINANCIAL 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be SOL SURASKY PAULINE STEIN P 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12522 VALLEY PINES DRIVE, REISTERSTOWN, MD 21136 CINDY SAVITZ / SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If its any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 01/04/2010 | FINKSBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical LATERAL SELEROSIS Examiner YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examine attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown cate has been signed by the a page 2 should be detached to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an performed? 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

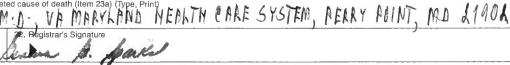
death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica

Baltimore, Maryland 21215-0036

Registrar

31. Date filed (Month, Day, Year) JAN 0 6 2010

L13A



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10066032

29d. Date signed (Month, Day, Year)

01-01-2010

DHMH 17 Rev 1/2001

2010 4:00 PM 4c. County of Death Harford 9. Birthplace (State or Foreign Maryland 10d. Inside City Limits 1 ☐ Yes 2X No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian. Black, White, etc. Specify: White 16b. Kind of Business/Industry Commercial Savings BAnk 18. Mother's Name (First, Middle, Maiden Surname) Ida Elizabeth Nafzinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2812 Harford Road - Fallston, Maryland 20c. Location - City or Town, State Fork U.M. Church Cem. 01/06/2010 Fork, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 Approximate Interval Between Onset and Death 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) S. Roog coraj. 0053720 01/04/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 602 S. Atusood Rd HOG, Belair, MD 2004. S. Ragcoraj. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician Mont O<sub>2</sub> 20 ເດັ Caroline Elizabeth 23:25 M Thornton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Co. Hospital Westminster Carroll 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🗓 F **Director** 215-30-0465 76 02 27 33 NC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, its Medical Exercite that the colling of once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1610 The Strand 21157 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes X☐No Specify: Specify: Black 2 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12th grade State of Maryland 4yrs <u>Research Analyst</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Milton Earle Thomas Elnora Whitt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Thornton-Son 1610 The Strand, Westminster, Md 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley 1/7/2010 Dulaney Valley, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 3a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immuliate Cause (Final Physician COMMON disease or condition resulting in death) /Medical Due to (or as a consequence, of): Examiner abete equentially list constions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed ser Tens Box 68760.♥ IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐Yes 2 ☑No 1 □Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ PA/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1∐Yes 2∐No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier within 2. and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30x Name and address of person who completed cause of death (Item 23a) (Type, Print) Poid Blad JE PHONE A 1005 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 02 2010 03:35 01 Frederick Donald Turner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Randallstown Baltimore Season's Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Days Months 1 X M 2 □ F 215-28-3014 30 79 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 XYes 2 No Director Windsor Mill MΠ NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21244 3143 Jeffland Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Housing Auth. of Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City 12th grade 4yrs Housing Manager

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakeview Memorial 1/9/2010

18. Mother's Name (First, Middle, Maiden Surname)

Reisterstown

20c. Location - City or Town, State

Sykesville, Md

Grace Brown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3143 Jeffland Road, Baltimore, Md 21244

**Physician** /Medical Examiner

**Funeral** 

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hilury or other traumatic event, the Medical Examiner must be notified at once.

Be

17. Father's Name (First, Middle, Last)

Frederick Turner

20a. Method of Disposition

19a. Informant's Name/Relationship (Type. Print)

1 ▼Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

6

MD

32. Registrar's Signature

Pauline Turner-wife

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-tran Physician/Medical been signed by the should be detached þ Completed After this certificate has funeral director, page 2 : Be Certification: To ours after death.

neral Director: A
filled in by the fu To the Hospital within 24 hours a To the Funeral C completely filled Medical

or Attending Physician: The law requires that the death certificate be executed

the Hospital

Division of Vital Records, P.O. Box 68760,

of Funeral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1-7 years disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2- No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D37573

DHMH 17 Rev 1/2001

State

Registrar

Mais

		For State Registrar	State of Mai	-	ertificate of		ivientai riy	Reg. No. )	10 00121	
Dhuaisi		1. Decedent's Name (First, Middle, L	·				2. Date of De	eath Day	3. Time of Death	
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Examir	er	4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town,	or Location of Dea	ath	4c. County	y of Death	
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Funeral		,	1 □ M 2 😿 F	(In yrs. last birthday Yrs.	Months Day		n. (Month, Da	ay, Year)	Birthplace (State or Foreign Country)	
Director		214-30-2711 Usual Residence of Decedent	99				11–25–	1910	VA	
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r dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13	Was Decedent of If Yes, specify Cu	f Hispanic Origin? uban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	o- 14. Rad Bla	ce - American Indian, ack, White, etc.	
36 s afte	by F	1  Never Married 2  Married 3  Widowed 4  Divorced	1 □ Yes 2 No If Yes, Give Year or Dates:	)	1 ☐ Yes 2 N	o Specify:		Specif		
lore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ed t	15. Decedent's		16a. Dec	edent's Usual Occ	upation		16b. Kind of B	BLACK Business/Industry	
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212	E O	8	College (1-401 5+)		SERVICE	WORKER		BALTO	. CO. SCHOOLS	
be file tal Hy d othe event,	Be C	17. Father's Name (First, Middle, La	st)			18. Mother's N	ame (First, Middle	, Maiden Surnai	me)	
Ments	일	GRANT TYLER				SUSI	E DANDRI	DGE		
and sauma		19a. Informant's Name/Relationship	(Type. Print)	19b. Mai	ling Address (Stree	et and Number or	Rural Route Numb	er, City or Town	n, State, Zip Code)	
and and m 27		JAMES A. TYLER,	SON			GON RD.				
Baltimore, permit. Pages 1 at Department of Hea Important: If item any Injury or othe		20a. Method of Disposition 1 X Burial 2 □ Cremation 3	☐Removal from State	20b. Place of Disp cemetery, cr	osition (Name of ematory or other p	lace)	Date	20c. Location	- City or Town, State	
Lim Pag trment tant: jury		4 ☐ Donation 5 ☐ Other (Spe	oify)			L PK. 1-			MORE, MD	
Baltimo permit. Pages Department of Important: If any Injury or once.		21. Signature of Funeral Service Lic	ensee						S SONS F.H., INC.	
		James Cs.	Morto	2		LAURENS		TIMORE,	MD 21217 Approximate	
		23a. Pard . Enter the disease, or co shock, or heart failure. List on	ly one cause on each line	ne death. Do not el	nter the mode of d	ying, such as card	ac or respiratory a	arrest,	Interval Between Onset and Death	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a STROKE							
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* * **********************************	F.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. HYPETTE Due to (or as a	consequence of):						
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Box 68760, eath certificate be executed attending physician and for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pt 1 ☐ Live birth 2		□Ectopic pregnar	nev			ate of delivery	
deat death	sicis	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregnant at ti 9□Unknown		Other (specify)			↑ M	Ionth Day Year	
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Division or Vital Rec To the Hospital or Attending Physician: The law Within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Ex	aminer: On the basis of e and manner state		investigation, in m	y opinion, death o	courred at the time	, date and place	, and due to the cause(s)	
To the within 2 To the comple	Me	29b. Signature and title of certifier	11	,	29c. Lice	nse number		29d. Date signe	ed (Month, Day, Year)	
r		1 mouse	Land	MM	Din	2032		JANUAR	4 5 2010	
		30. Name and address of person wh	o completed cause of dea	ath (Item 23a) (Type	, Print)				+	
		JENNIFER HAYAS		HOPKINS	BAYVIE	V CIRCL	E BALT	IMORE,	MD 21224	
Sta		31. Date filed (Month, Day, Year)	32/Registrar	's Signature	arked			ľ		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month ace -38PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town or Location of Death 4c. County of Death 5. Social Security Numbe . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛚 F 077-01-8840 Months Days Hours Min June 13.1920 Director 89 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Baltimore Marvland Essex 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 USA 1800 Kitty Hawk Rd. death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceded... Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", Specify: Completed 3xxWidowed 4 ☐ Divorced White event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) 12th grade should be filed within and Mental Hygiene. Homemaker Homemaking-Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Glenn Lincoln Judd Cecile Holbrook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .00 permit. Page 1 and 2 sh Department of Health a Important; If item 27 is any injury or other trai 222 Stevens Rd. Baltimore, Md. 21220 Pam Arnett (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial XX Cremation 3 ☐ Removal from State cemetery, crematory or other place Metro Crematory, Inc. 1-5-2010 Baltimore, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lassann Funeral 7401 Belair Rd. Home Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final and De th Physician/ nonaw disease or condition resulting in death) a Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 the attending ph IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Year ed by the a detached f 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 XNO Completed 1 Yes 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed certificate 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 00 မ PICE 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year,

29b. Signature and title of certifier

30. Name and address of person

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Charles St. Baltimore, UD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per Fh 2899 1/11/10 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** а м 7:30 MARTE WADDELL Januarv 2010 AMY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Grace Lodge Brook1yn If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y August 21, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year Hours 1 M 2 M F Months Days 212-16-<del>4947-</del> **4974** 89 1920 Maryland | Director Usual Residence of Decedent 10c. City, Town or Location 10b, County 10d. Inside City Limits 28a-f show traumatic event, the Medical Exeminar nost be notified at 1 ☐ Yes 2 No Maryland Charles : Hughesville Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 14023 Oaks Road 20637 U.S.A. 'natural", or items 23a Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 \( \text{Yes} \) 2 \( \text{No} \) No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White If Yes, Give Year or Dates: Specify: Completed by Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if flem 27 is marked other than "any injury or other trainmetic. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Edward Davis Curry Mary 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria J. Purvis 14023 Oaks Road, Hughesville, Maryland 20637 (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 01-06-10 Glen Bernie, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21. Signature of Fund Service License Minx 237 Fast Patapsco Avenue, Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final sease or condition resulting in death) **Physician** eneutor 4 eady /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial P.O. Box 68760, physician Physician/Medical the attending p for use as as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Arterios dester Corman 1 Yes 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s jorceter. autopsy performed: certificate Breaut Cancer 2,₺ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann f Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D1966 01-04-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \* 508 Glen Bring, Cayland 21001 Lucy Ritchie Hy Phomoel (aucout20 7310 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 6 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per fh 8899 1-7-10 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical Facility Name (If not institution, giverstreet and number) 4b City Town, or Location of Death 4c. County of Death Examiner N/AIf Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1□M 2 F Months Days Hours Min. T Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Marical Exercises must be realified at any injury or other traumatic event, If a Marical Exercises must be realified at appear. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1123 N. Gilmor Street 21217 Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban-Wexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 No Specify. Completed by Specify: 3 Widowed 4 Divorced Black 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Private Nursing Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Agency CNA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Coleman မှ William Branch Alston Lily Anna Mae 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lily Alston(Mother) 1123 n. Gilmor St., Balto., MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Western Star Cem. 01/09/10 Baltimore, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Joseph H. Brown Jr. Funeral Home um 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown ģ s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 2 **X** No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1⊠Yes 2⊟No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) To the I within 2. and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LEONARD ALLEN 443 ANUARY 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE Social Security Number If Under 1 Year If Under 2 . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 X M 2 □ F Months Davs Hours Min 83 219-10-7797 Baltimore Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a State 10c. City Town or Location 10d. Inside City Limits Director MD Dunda1k 1 Yes 2 X No Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 Funera 1969 Frames Road United States death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent Ever III 0.0. Armed Forces? 1 ☑ Yes 2 ☐ No Korean If Yes, Give Year or Dates. WWII 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 No Specify. Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. item 27 is marked other than Stee1 Elementary/Seconday (0-12) College (1-4 or 5+) 7 Years Steel Hooker Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lula Frances Weaver Van Buren Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1969 Frames Road Dundalk, Maryland 21222 Grace Allen (Wife) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 8 Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Holly Hill Mem. Gdns. 1/7/2010 Middle River, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Wise Ave. Dundalk, Maryland art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final UNCAL HERNIATION ( Physician BRAIN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) HYPOTENSION burial-trai physician the burial Physician/Medical MYOCARDIAL INFARCTION that the death certificate be 6 DAYS Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Physician; The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: <u>م</u>| 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending iniury 1 ANatura 5 Pending work? 1 ☐ Yes 2 ☐ No. М after death

Director; A

in by the f Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in I within 24 hours a

To the Funeral I

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) MD RES-000 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar JENEEN

31. Date filed (Month, Day, Year)

M GIFFORD, MD

4940 EASTERN AVENUE

BALTIMORE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per dyr 8899 1-7-10 vt
State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 00126 State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Elizabeth Brown 1 0ear 6:45a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilcrest Hospice Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) 1 □ M 2**X** F (Month, Day, Months Days Hours Min. 212-42-1083 **Director** 69 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD N/A Baltimore 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 21215 ò 10g. Citizen of What Country? Funeral 23a 2304 Oswego Ave UŠA or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White, etc. African Specifimerican ģ 1 Never Married 2 Married Maryland 21215-0036 Yes Give 1 ☐ Yes 2X No Specify "natural", Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Homemaker permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiera Important if item 27 is marked other than any injury or other traumatic constant. Self Elementary/Seconday (0-12) College (1-4 or 5+) 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Paige Fannie M. Yerby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred J. Tubman/Daughtr 2304 Oswego Ave, Balt., MD 21215 3altimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/15/10 Garrison Forest VA Owings Mills,MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Sen ce Licensee 22. Name and Address of FacilityHari P. 22. Name and Address of FacilityHari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Er er the disease, or complications that caused shock, or heart failure. List only one cause on erich line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Immediate Cause (Final **Qnset and Death** Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner dequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 youths?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant g ☐ Unknown the a detached 9 Unknown P.O. signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 XI/Probably 4 □ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate ! 1 🗆 Yes 2 🗆 No Yes 2 Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence Hospital ဂ MOSPICE 1 Inpatient 2 ER/Outpatient 3 IDOA 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Dea Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 6 (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AANON T WANLES MY (670) 32. Postrar's Signature 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G899, 1/7/2010, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:00 P M BRILLIAN-2010 Louis /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and nu Examiner BALTIMON 2700 N. CHANIES ST N/A If Under 1 Year | If Under 24 Hrs. | 8. 9. Birthplace (State or Foreign 5. Social Security Num 089 Date of Birth (Month) Day, **Funeral** Days Months 2□ F MD Director Usual Residence of Decedent 10d Inside City Limits 10a. State 10c. City, Town or Location r 28a-f show notified at 1 X Yes 2 □ No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be n 6309 WIRT AVENUE 21215 Funeral 14. Race - American India Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: WHILE Saltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) Coilege (1-4or 5+) OPTOMETRIST OPTOMETRY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOUIS 2 BRILLIANT **ESTHER** KRAMER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any Injury or other traun 6309 WIRT AVENUE, BALTIMORE, MD 21215 MARGOT BRILLIANT / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State DHEL YAKOV BETH ISRAEL 4 ☐ Donation 5 ☐ Other (Specify 1/6/2010 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC 21. Signature of Funeral Service Light 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one rause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ANOXIC Bram /Medical Due to (or as a consequence of): Examiner Dr adresson Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner Chrome Hospital or Attending Physlclan: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9∏Unknown 9 ☐ Unknown cate has been signed by , page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ HO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D31469 5/10 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q SHUAIIS A. HASHMI MD 821 N. EUTAW ST Snite 308 BALTIMORE MD 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar <u>Jan u 7 2010</u>

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ) Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4c. County of Death Name (If not institution, give street and number) Examiner TIMOLE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 9,1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 1 □ M 2√2√5 213-03-5759 July 90 Director MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at N/A 1 XXes 2 □ No MD Baltimore Director 10q. Citizen of What Country? 10e. Street end Number 10f. Zip Code 21211 1413 Roland Heights Avenue U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2XXNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: White Completed by 3√∃Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Easton ဂ Pearl Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1116 Weldon Avenue Balto, MD 21211 Mary Manning (Niece) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)

Lorraine Park Cemetery 1 X Yurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1/7/2010 Balto, MD 22. Name and Address of Facility. Burgee-Henss-Seitz Funeral Home, 3631 Falls Road Balto, MD 21211 21. Signature of Euneral Service License 23a. Part1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Due to (or as a consequence of): Dechne disease or condition resulting in death) /Medical Examiner Christovaser Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit that the death certificate be executed Domentia that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atterpage 2 should be detached for a Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 2 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 2 DN To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certified 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 은 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D31464 MD

3

DHMH 17 Rev 1/2001

Registrar

ST suite 308

BALTIMORE MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHOAIR A. HASHMI MD &21 N. EUTAW

31. Date filed (Month, Day, Year)-

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death acedent's Name (First, Middle, Last) Month Physician 1:06 AM <u> 2010</u> /Medical 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. te or Fareian cial Security Number 7. Age (In yrs. last birthday) **Funeral** 62.55 **Director** Usual Residence of Decedent side City Limits 10b. County notified at ¥Yes 2 □ No Funeral Director 28a-f 10g. Citizen of What Country? 10f. Zip-Code eet and Number ö ral", or items 23a o Examiner must be permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23: any highry or other traumatic event, the Medical Examiner must I once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 NO 1 Never Married lack 1 Yes 2 No Maryland 21215-0036 Specify. Completed by 4 Divorced 3 Widowed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working fiel DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) lary (0-12) College (1-4 or 5+) 18. Mother's Name (First, Middle, Maiden Be 19b. Mailing Address Baltimore, 20a. Method of Disposition 1 🖫 Burjal 2 Cremation 3 Removal from State 5 Other (Specify) 21. Signat 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician Massive disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician an Division of Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Live birth Month ó in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Tyes 2 1 Yes this certificate 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other Hospital 2 X No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) 1 Inpatient မ 28c. Injury at Work? 28d. Describe how injury occurred Date of Injury 28b. Time of 27. Manner of Death Certification: 5 Pending investigation 1 Natural 2 Accident After (Month, Day Year, Injury 1 Yes 2 No n 24 hours after death.

e Funeral Director: Aft
bletely filled in by the fu 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 😾 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

JY

State Registrar 31. Date filed (Month, Day, Year)

CHRISTOPHER

(ear) 32. Degistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ignature . Saxle

600 North Wolfe St, Baltimore, MD, 21287

Affred G. Byrd 10-00005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

INK UNK		1- For State	tate of Maryla		partment ertificate			Menta	al Hy	_	Reg. No.	201	0	00131
Physicia	an/	Registrar  1. Decedent's Name (First, Midd)	le,Last)							2. Date of De	ath Day	Year	- 1	Time of Death
Medical Exami	ner	Alfred Gilli	ian Byrd					et a af		January	1, 201	10		0200 hrs
		4a. Facility Name (if not institution 975 Bay Ridge Road	n, give street and nu	umber)		4b. City, T		ocation of	Deatn		- 1	lc. County of De Anne Arund		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	<u> </u>	er 1 Year	If Under	24Hrs.	8. Date of B	Birth (MM	A/DD/YYYY) 9.	Birthpla	ace (State or
Director		216-08-3743	1XM 2 F	40		Yrs. Months	s Days	Hours	Min.	Aug.	21	, 1969	<b>G</b> ign Country	Maryland
		Usual Residence of Decedent	l											
w any		10a. State 10b. County	Arundel		ity, Town or Loc nnapol									d. Inside City Limits  Yes 2 X No
Aaryland 28a-f show 1 at once.	후	Maryland Anne	HIGHGE			10f. Zip	Codo				10a Cit	tizen of What C		
th the Maryland 23a or 28a-f sh <u>notified at once</u>	Director					214					USA		ourning:	
with the 18 23a e noti		1212 Louis Ro		cedent Ever in		Was Deceder	nt of Hisp			ecify Yes or N	lo-			Indian, Black,
death v	Funeral	1 Never Married 2 M	farried Armed Fo	orces?		f Yes, specif	y Cuban,	Mexican, F	Puerto R	tican, etc.)		White, etc Blac		
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	by F		vorced If Yes, Give Yea or Dates:	ar	1			specify:				Specify:		
hours 'natur Exam	peg	15. Decedent's Education (Spe Elementary/Secondary (0-12)		1-4 or 5+)		dent's Usual ( most of work						Kind of Busines		
5-0036 led within 72 hours afte tygiene. other than "natural", the Medical Examine:	Completed	10th Grade	College (	1-4 OF 5+)	Coc	)k					Re	estaur	ant	:
5-0036 led within Hygiene. other tha		17. Father's Name (First, Middle								(First, Middle,	Maider	n Surname)		
2121! Muld be fil Mental F marked c event, g	B	Lorenzo A. B								Rico				
MD 21215-0036 d 2 should be filed within 7 tht and Mental Hygiene. n 27 is marked other than numatic event, the Medica	٩	19a. Informant's Name/Relations  Joanne R. Ha		-her	1196. Maii	ing Address Lou	is R	and Numb load	er or Ru Anr	ıral Route Nu 1apol :	imber, u is, l	City or Town, St. Maryla	iate, Zip i <b>n</b> d	21403
r g g a r	1	20a. Method of Disposition		20b	b. Place of Disp	oosition (Nam	ne of ceme			Date	20c.	Location - City	or Tow	vn, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation	_	om State Ki	crematory or ng Men	other place) noria	l Pa	ark	1/8	3/2010	0 W	oodlaw	n,l	Maryland
Baltimore permit. Pages 1 Department of I Important: If i	-	4 Donation 5 Other S 21. Signature of Funeral Service			22	2. Name and	Address	of Facility	Cha	atman.	⊥ -Ha	rris F	une	eralHome
	1		ris						stov	wn Rd	Ва	ltimor	ce,l	MD 21215
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that c on each line.	aused the dea	ith. Do not ente	r the mode o	of dying, s	uch as car	rdiac or	respiratory ar	rrest, sh	ock, or heart		pproximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)		juries a consequence	- ^f\·								+	Death
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	iner	if any, leading to immediate cause. Enter Underlying Cause		a consequence	⊋ of):									
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O, be existian sician burial	edical	UNPENDED	AMENDED								- 12			
Division of Vital Records, P.O. Box 6876C the Hospital or attending Physician: The law requires that the death certificate hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physinpletely filled in by the funeral director, page 2 should be detached for use as the b	Ž/C	IF FEMALE: 23b. Was decedent pregnant in the		outcome of pre birth		Fetal death	3	Ectopic p	pregnan	ісу	23	3d. Date of deliv Month	very Day	Year
Box 6876 death certificate the attending phy	sicia	past 12 months?		nant at time of	4	Other (Spec	cify)							
P.O. Bo that the dea ned by the a detached fo	Physician/M	Part II. Other significant condit	a outri		at resulting in th	e underlying	cause giv	ven in Part	11.	23e. Did	tobacco	use contribute	to the	cause of death?
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of Vital Records, ng Physician: The law require wher this certificate has been si meral director, page 2 should t	dmo				_					auto perfo 1 <b>V</b> Yes	ormed?	death	1?	pletion of cause of
Vital Rec ysician: The l his certificate l director, page	o l	25. Was case referred to medica	al			2	26.Place o	of Death (C	Check or		٠	, <u>~</u>	163	2
Vita hysicia this cea	9	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatie	ent 3 D	0A 0	Other	Nursing	Home 5	Reside	lence 6 🗸 Oti	her: Sc	ene
1 Of ing Pt After funera	Ë	27. Manner of Death	28a. Date	of Injury h, Day,Year)	28b. Time of	of Injury 2		at Work?	le.	28d. Describe Pedestrian		jury occurred k by motor v	vehicl	e
Sion Attend death ector:	catic	Natural 5 Pending Investigation Investigation Accident 2 Accident 2 See. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Circumstance Symbot												
Division ospital or Attendi hours after death.	Certification:	dete	lid not be	ce of Injury - At Major Ro		reet, ractory,	, office pur	ilding, etc.	100	or Town,	State)	and Number or ad, Annapolis,		Route Number, City
Division of Nospital or Attending Phe Hospital or Attending Phe Phours after death. Funeral Director: After telly filled in by the funeral	20	4 Homicide	hysician: To the bes			curred at the	time, date	e and plac	-		_			
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cau (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.												use(s)		
F 3 F 3	§ S	29b. Signature and title of certific		Λ		29c	. License					Date signed (I		Day, Year)
January 1, 2010								10						
4	ı	30. Name and address of person				n Street, E	Raltimo	re MD 1	21201					
		Carol Allan, MD As  31. Date filed (Month, Day Year)	sistant Medical	egistrar's Signa	and the same of									
Si Regist	tate	31. Date filed (Modern Bay 1 ear)	2010	a salana a	1. 00	Explant								

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:00 AM Anna Bonito ï 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Havre de Grace Harford Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 1/3/1924 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. 1□M 2₹ F Months Hours Italy **Director** 214-58-5267 86 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Innortant: I fier 7 is narked other than "natural", or items 23a or 28a-f show any Injury; or other traumatic event, it a restice Event could be matter. 1 Yes 2 □ No Director Harford Aberdeen Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Italy 21001 458 Roberts Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify. Yes. Give Specify: White ģ 3 Widowed 4 □ Divorced Ye ar or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Matteo Yerman Unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 739 Earlton Rd, Havre de Grace, MD 21078 Karen T. Cardinal (executor) 20c. Location - City or Town, State West Chester, 20b. Place of Disposition (Name of cemetery, crematory or other place)
R.A. Ferris & Co. 20a. Method of Disposition Date 1 Burial 2 remation 3 Removal from State 1/7/2010 Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service bicensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician ar Due to (or as a consequence of): of Vital Records, P.O. Box 68760 Completed by Physician/Medical been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 No 1 □Yes Hospital or Attending Physician: after death.

Director: After this certific
in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To 📶 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) onoo 31. Date filed (Month, Day, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 05 Day Physician 20 ັ່ງຕື່ 8:05 P M Theresa Frances Barrett /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson, MD Holly Hill Nursing Home If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Month, Pay, Year 5/30/1909 Days Hours 220-14-7829 1 □ M 2√xF 100 Baltimore, MD Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2√ No Director Baltimore Towson MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21286 531 Stevenson Lane, Towson, MD by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: white Specify 3€XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Thanner John Brutsbher ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7652 Belair Road Baltimore, MD 21236 Nomiki B Weitzel / Attorney 20c. Location - City or Town, State Date Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Pk. 1/11/2010 Baltimore, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Towson, MD 21204 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ruck Towson Funeral Home, Inc. 1050 York Road Approximate interval Between Onset and Death disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) I∐Yes 2∐TNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **p** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☑No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 1 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Division of Vital Records, e Hospital or Attending F 24 hours after death. e Funeral Director: After

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exacting the Indifficult at once.

**Physician** 

Examiner

/Medical

sician and burial-trans

**To the Funeral Director:** After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) State **JAN 07** Registrar

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 407

and manner stated

#301

Registrar's Signature

To the l within 2. To the l

Registrar DHMH 17 Rev 1/2001

OCMF 2006

State

29b. Signature and title of certifie

30. Name and address of page Jack Titus MD.

31 Date filed (Month, Day, Year)

rson who completed cause of death (Item 23a)

32 Registrar's Signature

Deputy Chief Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 3, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomer 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Country) Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2078 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 If Yes, Give Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BIACK Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medicone. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) chard 19a. Informant's Name/Relationship (Type, Print) (day) ntcr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CaldWell 20a. Method of Disposition

1 
Burial 2 Cremation 3 
Removal from State 20b. Place of Disposition (Name of Crematory. Riverdale 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Georgia ave 1182 chington DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** POXE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical been signed by the attending I should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Year Day Pregnant at time of death Yes Unknown g 🗌 Unknown Records, P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 🗌 No **Division of Vital** ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Hospital: Other: 2 X No ျ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural 5 Pending 2 Accident 3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours at To the Funeral D completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) Korapati 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per dvr g899 I-7-10 vt State of Maryland / Department of Health and Mental Hygiene 00136 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Yvonne Jan. 2:40PM Lee Cramer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Forest Hill Health & Rehab. Harford Forest Hill If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, ) June 21 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Months Year 1 ☐ M 2 🔀 F Country) Virginia ,1937 Director 216-34-8912 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Harford Bel Air 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21014 United States 1224 Brighton Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2XXNo Black, White, etc. þ 1 Never Married 2 x Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify: If Yes, Give Year or Dates Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 9 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edna Harliss James Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bel Air, Maryland 21014 1224 Brighton Lane Lester B. Cramer (Husband) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial ② Cremation 3 ☐ Removal from State Hilltop Service Corp. 1/6/2010 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Duda -Ruck Funeral Home of Dundalk, Inc.
Dundalk, Maryland 21222 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland art 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown in the past 12 months? Month Day Vear Pregnant at time of death ed by the a 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown has been sign 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate har ral director, page death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at s after death.

I Director: After to in by the funeral 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 2 Accident Natural 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completed filled in by t 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical 29a. Certifier 🎮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Dans S D3221 JAn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6:5 Belair W. Maclhal

State Registrar 31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Date of Death Month Decedent's Name (First, Middle, Last) 3. Time of Death 20K 4c. County of Death 4a. Facility Name (If not institution, give street and number) Seasons Hospice@Northwest Hospital Ranual Second Property Research Ranual Ranua Baltimore Randallstown 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Hours 1 □ M 🕱 🗆 F Davs 86 216-32-7539 Maryland AUG 20, 1,923 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 TyYes 2 □ No Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21207 5302 Peerless Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 🛛 No If Yes, Give Year or Dates: Specify: 3√ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private families Domestic 6th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Hall Louise Nelson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 3327 W. Forest Park Ave Baltimore, MD Tamela Batts-Woodson/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition /11<sup>Date</sup>/2010 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. Cemetery Owings Mills, MD 21. Signature of Funeral Se vice License 22. Name and Address of FacilityChatman-Harris Funeral Home Reisterstown Rd Baltimore, Md 21215 arris 5240 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 3 Ectopic pregnancy Month Year Day

**Physician** /Medical Examiner

permit. Pages 1 and 2 s
Department of Health as
Important; If item 27 is
any Injury or other trau

**Physician** /Medical

**Examiner** 

Director

Funeral

2

Completed

Be

**Funeral** 

Director

1 and 2 should be filed within 72 hours after death with the Marylar Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exp. in a market to a rolling of the content of the Medical Exp. in a man and the content of the Medical Exp. in a man and the content of the Medical Exp. in a man and the content of the Medical Exp. in a man and the content of the Medical Exp. in a man and the content of the Medical Exp. in a man and the content of the Medical Exp. in a man and the content of the Medical Exp. in a man and the content of the Medical Exp. in a man and the content of the Medical Exp. in a man and the content of the content of the Medical Exp. in a man and the content of t

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

of Vital Records,

Division

I or Attending Physician; after death.

To the Hospital within 24 hours a To the Funeral C

Examine signed by the attending physician and detached for use as the burial-trans s peen si should I s certificate has tirrector, page 2 s neral Director: After this certific filled in by the funeral director,

Physician/Medical Completed by Be Certification: To

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an autopsy performed 1 ☐Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 24 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

M

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

29b. Signature and title of certifier

JANO

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name

29d. Date signed (Month, Day, Year)

Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes

2 No

State

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 \right Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nonth Physician /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Season's Hospice Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours **1**√2 M 2 □ F Days 204-24-6563 PA Director 76 31. Aug. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Medical Examiner must be modified at once. 28a-f show Yes 2 No Director MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5606 Clifton Avenue 21207 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 □XNo Specify: Black þ Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembler Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Diggs Jenkins Lena ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5606 Clifton Avenue, Baltimore, MD 21207 Marguerite Diggs / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crem. 1/6/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services 21. Signature of Funeral Service Licensee Dorota Marshall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car liac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 2 [ 25. Was case referred to medical Be 26. Place of Death (Check only oné) examiner? Other: 4 Nursing Home 5 Residence 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dose up 283

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar

Server S. Sare

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:29 AM January 2010 John Henry Eney Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Hospice Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday Funeral **X** M 2 □ F Days Months Hours (Month, Day, Mary Land 56 Sep. **Director** 214-64-6395 Usual Residence of Decedent 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 √2 Yes 2 □ No N/A Baltimore 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21224 421 Elrino Street United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black White etc. þ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Cook Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Kenneth Eney, Sr. Catherine Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IANUARY 1, Elrino Street, Baltimore, MD 21224 Denise Kropp - Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of West Arunder on ther place) Burial 2 Xremation 3 Removal from State 4 Donation 5 Dother (Spesify) 1-6-2010 Glen Burnie, MD Crematory Fineral Service License 22. Name and Address of Facility Ambrose Funeral Home, Inc. Signatu 2719 Hammonds Fry Rd., Lansdowne, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician a PANCREATIC CANCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to for as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): physician Physician/Medical Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy ate has been signed by the atter page 2 should be detached for u in the past 12 months? Month Year 5 Other (specify) Day Pregnant at time of death Yes 2 No 9 🗔 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2 **X** No HOSPICE |은 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 5 Pending 2  $\square$  No death. 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director;

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the I only one 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 CRNP State

DHMH 17 Rev 7/2009

Registrar

10:29 a.m.

JOHN ENE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 9:15 A M Mary Jane Eckerle 5 2010 Jan. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Parkville Oakcrest If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) July 17 1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 ▼ F Ohio 94 Director 707-18-6116 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and the firem 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or hitem and be notified at any or other traumatic event, Ita Mocified Is a miner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 □ Yes 2 No Parkville Baltimore MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 8820 Walther Blvd. #4022 21234 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Railroad Secretary n/a 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alethea Elizabeth Sellers George William Eckerle ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8820 Walther Blvd. #4022, Parkville, MD 21234 Betty E. Eckerle/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or c 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 1/06/10 Glen Burnie, MD Atlantic Crematory 4 □ Donation 5 □ Other (Specify) Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Funeral Services Michael J. Hagie 23a. Part 1. Enter the disease, or complication. Plat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Coronary artery disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by the ο. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Š 1 ☐ Yes 2 ☐ № 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes Vital Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Certification: To of After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Division Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier cal (Check only one)

Registrar DHMH 17 Rev 1/2001

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29b. Signature of title of certifier

Michealle

31. Date filed (Month, Day,

Galle

Year)

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2010

1/5/

CRUS MX

29c. License number

R171944

CENT MIN 8800 Walther Blvd, Packville, MD 21234

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harrison

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AMEND TTEM#19a, perFH, G899, 177/2010, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY PAUL FRIEDMAN 2010 12:37P <sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Birtnpisco Country) MD 1 🗶 M 2 🗆 F Months Days Hours Min. 472071920 217-16-4807 89 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3916 ZURICH ROAD 21133 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) OWNER PAINTING / LETTERING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental ပ္ ISRAEL FRIEDMAN IDA GOLDINER Hilda Shirley Friedman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 SHIRLEY FRIEDMAN / WIFE 3916 ZURICH ROAD, RANDALLSTOWN, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JACOB CEMETERY 1/6/2010 |BALTIMORE, MD Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each lin Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ner Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires To Be Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 No 1 Tyes 25. Was case referred to medical of Vital 26. Place of Death (Check only one) examiner? 2 X No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) 6 1 Chris 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 24 hours after death. Funeral Director: After t Natural 5 Pending Division Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature 29d. Date signed (Month, Day, Year) 2 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St Suite 31. Date filed (Month, Day, Year) 82. Registrar's Signature State IAN 0 7 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2:488 Medical Facility Name (if not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner eNTER Lt. MURE 7. Age (In yrs. last birthday)
Yrs. If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State of Foreign Funeral 1 **X**M 2 □ F Months Days Min Director shov 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits be notified at Director or 28a-f 1 XYes 2 ☐ No timore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 21201 Funeral USA traumatic event, the Medical Examiner must items 12. Was Decedent Armed Forces? 1 M Yes 2 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. and Mental Hygiene. is marked other than "natural", or i Completed by 1 Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Glac 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired during most of working day (0-12) College (1-4 or 5+) dth permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event \*\* Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden ည 19a. Informant's Nac e/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-2010 reen 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on yach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ 0 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Specific time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No ed by the a Unknown 9 Unknown P.O. I s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 1 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 E 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗖 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

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State of Maryland / Department of Health and Mental Hygiene 2 | | | State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Goldsborough 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hosp. Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Sept • 20 Birthplace (State or Foreign Country)
 VA Social Security Number Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 🗆 M 2 🔀 F 212-26-6529 82 73 **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a, State Director MD N/A Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 751 W. Saratoga St. #219 21223 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2X No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ≥ Baltimore, Maryland 21215-0036 1 Yes 2XNo Specify: SpecifyBlack and 2 should be filed within 72 hours aft Health and Mental Hygiene. tem 27 is marked other than "natural", xther traumatic event, the Medical Exar 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Se 10th conday (0-12) College (1-4 or 5+) Waitress Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charlie Mitchell မ Fields Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanett Watkins/daughter 948 CrossWind Pl. Cockeysville, Md 21030 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Page 1 a 1 X Burial 2 Cremation 3 Removal from State Arbutus Mem. Pk. 1/7/10 4 ☐ Donation 5 ☐ Other (Specify) Arbutus, MD 22. Name and Address of Facility Betts Funeral 1129 N. Caroline St. Balto, 21. Signature of Funeral Service License Home Md 21213 Tatucia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Ulmonary Medical resulting in death) Due to (or as a consequative of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last use as the burial-trar Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IE FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an autopsy performe prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA
28a. Vate of injury 28b. Time of log-1 🗌 Yes 27. Manner of Peath 28d. Describe how injury occurred Certificate: 28c. Injury at (Month, Day, Year) 1 Natural 5 Pending work?
1 Yes 2 No M Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) 10 31. Date filed (Month. State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For Stete Registrer	State of Mary			of Health of Death			iene g. 2010	00144			
Physic /Med	lical	Decedent's Name (First, Middle, Last     John     Aa. Facility Name (If not institution, give)		Hall umber) 4b. City, Town, or Location of Death					2. Date of Death Month Day Year 3. Time of Death Ac. County of Death				
Exam	-3475	Gensis Health C  5. Social Security Number 6. Se	are	see to a hindred	Baltimore  If Under 1 Year   If Under 24 Hrs.				N/A				
Funera Directo	_		2 F 7. Age (#)	yrs. (ast birthday) 87 Yrs.		ays Hours	Min. 0	Date of Birth (Month, Day, 4/05/1	9. 1922 M	Birthplace (State or Foreign Country) aryland			
ire, Maryland 21215-0036 s. 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Evanthet must be calified at	Funeral Director	10a. State	:	Balti	more			10	ng. Citizen of Whal				
5-0036 72 hours after deat natural, or items 2	b	11. Maritaf Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	1					14. Race - A Black, V Specify:	merican Indian, /hite, etc.			
d 21215 filed within 72 Hygiene. ther then "ne ent, the Medic	Completed	(Specify only highest grades)  Elementary/Secondary (0-12)  9th Grade	ade completed) (G		icedent's Usual Occupation ive kind of work done during most of worki e. DO NOT use retired)  COOK				6b. Kind of Busine Federal	Government			
Maryland d 2 should be file th and Mental Hy 77 is marked oth traumatic event	To Be	17. Father's Name (First, Middle, Last)  John  19a. Informant's Name/Relationship (T)	Hall	105 14-22	an Address (O)	Car	rrie	Jon		-			
0 0		Rosella Hall (1	Wife)		Larue	sq.,I		.,MD 2	City or Town, State 21225  Oc. Location - City				
Baltimore, permit. Pages 1 a Department of Hea Important: If item any injury or othe		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens		Garriso 22					Baltimon	re,MD Home MD 21217			
BY60, sate be executed 'Medical Examiner uhysicien and the burial-transit	Examiner	23a; Párt1. Enfer the disease, or complete shock, crheart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	Cerebi nsequence of): Leusic nsequence of):			_	rombo		Approximate Interval Between Onset and Death  5 Minutes			
O. BOX 6: he death certific the ettending p shed for use as	Physician/Medical	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	3c. If yes, outcome of pre  1 Live birth 2 1  4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnal	felivery Day Year							
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on or ling Phy After this uneral d	ation: To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	lospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea.	2 ER/Outpatien 28b. Time of Injury	28c. I	0#	irsing Home						
P State	i Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	ecity)	_			City or Town,	State)	Rural Route Number,			
To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier (Clack with one)  1.4 Critifying Physical Learning Constitution of the Control of	sician: To the best of my ter. On the basis of exam and manner stated.	knowledge, death nination and/or inv	estigation, in n	ny opinion, dea	th occurred a	at the time, dat	e and place, and o	lue to the cause(s)			
(01/		30. Name and address of person who co	mpleted cause of death (	M) (Item 23a) (Type.	Print)	00145	9	, 8	Jon 5	anth, Day, Year)			
St Regist	ate	470 Penning 31. Date filed (Month, Day, Year)	Yon Ave	sa Ba	(fin	ore,	ude	2/2	26				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ MAN HONG KYOUNG 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORF BALTIMORE HUSPITAL HARBOR 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth 5. Social Security Number Funeral (Month, Day, 1 🗷 M 2 🗆 F 5 SORPA NONE Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State hours after death with the Maryland Director 1 Yes 2 ☐ No 2100tt 10g. Citizen of What Country? 10e. Street and Number Funeral 0 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White, etc. 1 Yes 2 No if Yes, Give 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16b. Kind of Business Industry 16a Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4RPPUH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname WOONG HONG UNKNOWY ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 00 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location City or Town, State 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 ETRO CRAMATON Tymeral Service License Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STAGE 4 LUNG CANCER WITH SYSTEMIC METASTASES Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by URINARY TRACT INFECTION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an PNEUMUNIA autopsy performed death? 1 ☐ Yes 2 ☑ No Yes 2 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 ₩ No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 27. Man er of Death 1 V Natural 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 5 Pending Investigation 6 Could not be 2 Accident
3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number KES 000 January 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD BAJAJ 3001 SOUTH HANOVER ST, ANMOLDEE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2010 Edward R. Hogarty, Jr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Agnes 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, 6, Sex 7. Age (In yrs. last birthday, **Funeral** Year) 1⊠M 2□ F 1918 91 19, **Director** 217-03-0152 Dec. Usual Residence of Decedent filed within 72 hours after death with the Maryland Hyglene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be rediffed at 1 ☐Yes 2X No Director MD Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21227 USA 1014 Downton Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🔽 No Specify. White δ Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Floor Mechanic Construction permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other? Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ Edward R. Hogarty, Sr. Marie Cavanaugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Hogarty Son 10315 Paddock Place; Laurel, MD 20723 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State injury or 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 1/9/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licenses 37 11015 1630 Edmondson Avenue: Catonsville, MD 21228 Approximate Interval Between 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final Phi **Physician** al disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical Physician: The law requires that the death certificate nding p as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Por 5 Other (specify) 1 ☐ Yes 2 ☐ No the Ö 9 Unknown signed by to d be detach σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed certificate 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

Division of Vital Records, e Hospital or Attending P 24 hours after death.
e Funeral Director: After t letely filled in by the funeral within 24 hours aft

To the Funeral Di

completely filled in

Registrar

29b. Signature and title of certifier

THIENG

29c. License number
DS2746

of death (Item 23a) (Type, Print) 220 Marden Choice Core bolt 2020

and manner Sated.

Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Russell Thomas **Hicks** January 4. 2010 1:29 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 11001 Gateview Road Cockeysville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 02-15-1954 1 🛛 M 2 □ F Months Days Hours Director 212-60-9682 56 Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 Yes 2 X No Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21030 U.S.A. 11001 Gateview Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than Baltimore County life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Paramedic Coordinator Fire Department 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Menr Important: If item 27 is marke any injury or other traumatic James Thomas Hicks Lena Belle Cadd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jason Thomas Hicks - Son 153 Bourbon Court Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c, Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State Hilltop Service Corp. 01-08-2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signuture of Funeral 2. Name and Address of Facility Leonard Ruck 5305 Harford Road Båltimore Maryland 21214 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conseduence of) **Examiner** HTK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Dav Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? Yes 2 No this certificate 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2**X** No Hospital Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Kesidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1. Natural 5 Pending ours after death.

neral Director: Af
filled in by the fu 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAME

831

RO93935

Skuenson

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 tems 5,7,8 per fh g899 1-7-10 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Har vev **Physician** ) an war 2010 01 /Medical 4b. City Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month), Days Year), Min. (Month), Days Year), Oct. 8, 1936 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months 213-32-8844 1★ M 2□F -85 73 Yrs. MD Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show Examiner must be notified at MD N/ABaltimore XXYes 2 □ No Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21231 U.S.A. Pages 1 and 2 should be filed within 72 hours after death with 201 N. Washington St. #313 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Medica (Give kind of work done during most of working life. DO NOT use retired) d other than " Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Assistant JHH Mental Hygiene. 8th N/A 18. Mother's Name (First, Middle, Maiden Surname) event, 17. Father's Name (First, Middle, Last) Be Wilks Vessie Richard Mason Harvey, Sr. 27 is marked or traumatic ever ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oliver St. Balto Md 21213 Barbara Harvey/spouse t of Health of item 27 i If item 27 or other t 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Trinity Ceme 1 Burial 2 Cremation 3 Removal from State 1/8/10 Balto., MD permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Betts Funeral Home atricia 1129 N. Caroline St. Balto., MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death nediate Cause (Final ase or condition Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and as the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? spital: Inpatient 28a. Date of Injury 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To After this c funeral di 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) After 1 Natural 2 Accident Pending investigation Injury 1 ☐ Yes 2 ☐ No death. Director: A Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hour.
the Funeral Directory filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical one) and manner stated within 2 the 29c. License number 29b. Signature and title of certifier TANKER 01, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

State Registrar JEAN

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31. Date filed (Month, Day, Year)

pake

600 North Wolfe St, Baltimore, MD, 21287

CAMPBELL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 2030 HRMAND 01 02 TOUMES Medical 2610 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Social Security Number 16. Sex BALTIMORE Medical CENTER If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 1923<sup>Count</sup>MD **Funeral** 215-12-0035 1 XM 2 - F Days Min. Ma(Youth Day 2'5") 86 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits Director ural", or items 23a or 28a-f s Examiner must be notified MD N/A Baltimore 1 X Yes 2 🗋 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 311 McMechen St. #325 21202 U.S.A. filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U.S. Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Black Year or Dates. WWII 1 ☐ Yes 2√☐ No Specify: 3 X Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 11th College (1-4 or 5+) Industry N/Ă Electrian alth and Mental Hygie 27 is marked other r traumatic event, tt Be 17. Father's Name (First, Middle, Last) Jest Marylar.

Jest Marylar.

Jermit. Page 1 and 2 should be files.

Department of Health and Merrillmportant: If item 27 in any injury or other. 18. Mother's Name (First, Middle, Maiden Surname) Albert Holmes, Sr. Pauline Raison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert Holmes, Jr./bro 1902 Ettings St. Baltimore, Md. 21217 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Ardent Crematory or other place) 1/7/10 Hanover, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beverly D. Cromartie F/S Signature of Funeral Service Licensee 2700 Edmondson Ave. Balto. Md 21223 23a. Per 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ TNEUMENIA- FSELGOMONAS (MOR disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Unknown P.O. Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? KENAL FAILURE, CAD, C. dIFF Division of Vital Records, 9 Hospital or Attending Physician: The law require 124 hours after death.
Performed Director: After this certificate has been significate the funeral director, page 2 should 1 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 Natural 5 Pending М Investigation Accident 6 Could not be To the Hospital or Atterwithin 24 hours after de To the Funeral Directo completed filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 01/03/10 1215162330 3+1 dress of person who completed cause of death (Item 23a) (Type, Print) BALTIMEE, MS C-GREENWOOD MHISL GREENE ST. 31. Date filed (Month, Day, Year) State JAN 0 7 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5 AM Nellie Mae Harrison Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western MD Regional Medical Center Cumberland Allegany Co. 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 M 2 AF Days Hours Min (Month, Day, Year) 2V 4 1917 Country) Director 215-80-9241 Virginia Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 U Yes 2XX No Maryland Garrett Co. McHenry 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 80 Wisp Mountain Road 21541 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 XWidowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 yrs. Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. ဂ္ Benjamin T. Anton Nannie Murren Sanford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 80 Wisp Mountain Road McHenry, MD Thomas Harrison /Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Nother (Specify) Entombment Glen Haven Mem Park 01/08/2010 Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 2nd Ave SW; Glen Burnie, MD 21061 M01121 Services PA: 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IE FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Year Day Pregnant at time of death 2 No signed by the a d be detached f g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page 2 performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No. 1 Natural 5 Pending s after death. Accident
Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) To the Hospital of within 24 hours a To the Funeral D completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier neures dress of person who completed cause of death (Item 23a) (Type, Print)

Registrar

lo

State

Khanna,

1221 National Highway

LaVale, MD 21502

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Hitte1 TANHARY Frank Martin 03 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Genesis Elder Care Severna Park Severna Park If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1∰ M 2□ F 83 217-20-0807 03-15-1926 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 ☐ Yes 2 ☑ No Severna Park Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21146 300 Pine Circle U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Purchasing Manager Westinghouse 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wilhelmina Miller G. Hittel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 861 Cottonwood Drive Severna Park, MD Mrs. Susan M. Lepley / Daughter 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01-10-2010 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility $1\ 2nd\ Avenue\ SW$ 21. Signature of Funeral Service Licensee Glen Burnie, MD Delena Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CHOLANGIO CARCINOMA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Yea 5 Other (specify) 1 □Yes 2 □ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ∠nknown 24b. Were autopsy findings available prior to completion of cause of death? CORONARY ARTERY DISEASE 24a. Was an autopsy performed 1 ☐Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner The law requires that the death certificate be executed

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

\$

Completed

Be

2

MD

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar mast be notified at

the Maryland

/Medical

attending physician and for use as the burial-transi signed by the a s peen si After this certificate has funeral director, page 2 s To the Hospital or Attendir within 24 hours after death.

To the Funeral Director A completely filled it by the fu

P.O. Box 68760,

Division of Vital Records,

or Attending Physician:

death.

Medical

State Registrar

Examine Physician/Medical IF FEMALE: <u>Ş</u> Completed Be Certification: To 1 Natural 2 Accident

9 Unknown

1 Yes 2 No 27. Manner of Death

6 Could not be

determined

28a. Date of Injury 28b. Time of (Month, Day, Year) 5 Pending investigation

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier im.

204.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8601 Veterans 170

NEC 31. Date filed (Month, Day, War)

gistrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 01 **Physician** Mary Kathryn Hunt /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Timonium Baltimore Lorien-Mays Chapel Nursing Home If Under I Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 6/15/1919 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 90 204-10-3669 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location "natural", or items 23a or 28a-f show traumatic event, the Medical Exacinary sust by notified at Director MD Baltimore Towson 10f. Zip Code 10e Street and Number 10g, Citizen of What Country? USA 21286 409 Virginia Avenue Apt. 419 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 No Specify 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker s 1 and 2 should be filed w f Health and Mental Hygier item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Merle Patterson Katherine Logan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code partment of Health al portant: If item 27 is Injury or other trau 8481 Timberland Circle, Ellicott City, MD 21043 Maureen Hinkle/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages
Department o
Important: If
any Injury or
once. 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 1/8/2010 Towson 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical

Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IC CCMALC

only one cause on each line.	Onset and Death
-a Hypoxia	Days
Due to (or as a consequence of):	- 5
. Chronic Obstructive Pulmonary Disease	Years
Due to (or as a consequence of):	,
. Hx of Interstitial Lung Disease	Years
Due to (of as a consequence of):	1
d	
23c. If ves. outcome of pregnancy	divon

Examiner Physician/Medical ş Be Completed Medical Certification: To

or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

11 1
23b. Was decedent pregnant
in the past 12 mgaths?
1 ☐ Yes 2 ☑ No
9 Unknown

SC.		e of pregnancy
	1 Live birth	2 Fetal dea
	4 Pregnant	at time of death
	9 Unknown	

/	
ath	3  Ectopic pregnancy
h	5 Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

> Month Day

3. Time of Death

A M

3:50

9. Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

2018

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

2 No

25. Was case referred to medica examiner?
1 ☐ Yes 2 ☑ No

1 □ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA

1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Yes 2 🗆 No

2 Accident	invest
3 ☐ Suicide	6 ☐ Could
4 ☐ Homicide	deteri

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) mined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

autopsy performed

29a.	Certifier
	(Check or
	one)

1 Natural

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D61731

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NCHARLES ST., Ste 4105, BALTO, MD 21204 ROAN-CARDEN, MD 6701

31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/2001

thours after death.

uneral Director: A
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within 24 hours a

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Earl Ingemann-Si		- For State	tate of Mary		artment of He rtificate of De		Mental H	_	g. No. 20	10	00153
Physicia Medical Examin	n/	Registrar  1. Decedent's Name (First, Mide		2.2 .5				2. Date of Death Month January 2,	Day Year		Time of Death 2355 hrs
Wedical Examin		4a. Facility Name (if not instituti					ocation of Death		4c. County o	f Death	
		Johns Hopkins Hosp  5. Social Security Number Unix		7. Age (In yrs.		altimore Under 1 Year	If Under 24Hrs	. 8. Date of Birtl	h(MM/DD/YYYY)	9. Birthp	lace (State or
Funeral Director			1 M 2 F			onths Days	Hours Min		1988	Foreign	Amuda
nd how any	_	Usual Residence of Decedent  10a. State  10b. County	,	10c. City	Town or Location						Od. Inside City Limits  Yes 2 No
ne Maryla or 28a-f	Director	10e. Street and Number	11: // k	6.10	10	Zip Code	2	10	g. Citizen of Wh	at Country	? !
	Funeral [		Married Armed		If Yes, s	pecify Cuban, M	Mexican, Puerto	pecify Yes or No- Rican, etc.)	White		n Indian, Black,
nours after natural", Examiner	ক্র	15. Decedent's Education (Sp		rade completed)	16a. Decedent's U	sual Occupation	specify: n (Give kind of v OO NOT use reti	work done	Specify: 16b. Kind of Bus	siness/Ind	ustry
5-0036 led within 72 l Hygiene, other than "" the Medical E	Completed	Elementary/Secondary (0-12		(1-4 or 5+)	Dis	ableo	<u> </u>		Disa	16/	ed
21215-003 hould be filed withind Mental Hygiene, is marked other th	8	17. Father's Name (First, Middle Earl W	ilson			10	Wand	e (First, Middle, M	ncema		
MD 21 12 should 1 th and Mer 127 is man	٩	19a. Informant's Name/Relation  Wanda Ebb		ther	1,12,	dress (Street a	and Number or I Hill Ko	Rural Route Num	ndys N	1000	Bernuda
ore tra		20a. Method of Disposition  1 Burial 2 Crematic		1 from State	Place of Disposition crematory or other p		1	Date		City or To	
Baltimore, pernit. Pages I an Department of He Important: If ite		4 Donation 5 Other 3 21 Signature of Funeral Service		De	Ven day	and Address o	Facility Va U	shac.Ga	ecne Fur	rem	Bernuda Services
Physician		23a. Part I. Enjer the disease, of failure. List only one caus	or complications that se on each line.	t caused the deat	h. Do not enter the m	ode of dying, su	uch as cardiac o	or respiratory arre	da //3 #0\v est, shock, or hea	art)	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final diseas or condition resulting in death)		njuries s a consequence	of):					1	Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus	e	s a consequence	of):						
ted 1 1 1 1 1 1 1 1 1	Exami	(Disease or injury that initiated events resulting in death) Last	C.	s a consequence	of):						
.760, ficate be execute g physician and the burial - tran	dical	UNPENDED	AMENDE	D							
ding ertif	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 1 Liv	es, outcome of pre e birth egnant at time of c	2 Fetal d	eath 3 (	Ectopic pregna	ancy	23d. Date of Month	delivery Day	y Year
). Box the death c by the atten ached for us	Phys	Part II. Other significant cond		known g to death but not	resulting in the unde	rlying cause giv	ren in Part I.	23e. Did to	bacco use contri	bute to the	e cause of death?
ords, P.O. w requires that the seen signed by should be detacl	ed by			<del></del>				1 Yes			osy findings available
Division of Vital Records, talor Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director; page 2 should the fine by the funeral director; page 2 should the fine funeral director; page 2 should the funeral director for the funeral director fo	Completed				<u></u>			autop: perfor 1 <b>V</b> Yes	sy p med? c		appletion of cause of
Vital Rechysician: The this certificate	Be	25. Was case referred to medic examiner?  1  Yes 2 No		Inpatient 2	ER/Outpatient 3		of Death (Check Other: 4 Nursi		Residence 6	Other:	
n of V nding Phy th. :: After th	ion: To	27. Manner of Death	28a. Da	ate of Injury onth Day Year) , 2010	28b. Time of Injury 0330 hrs	I	at Work? es 2 ✓ No		now injury occurred to b		ision
Division Hospital or Attend 24 hours after death. Funeral Director:	ertification:	3 Suicide 6 Co	ould not be		home, farm, street, fa	ctory, office bui	ilding, etc.	28f. Location (S or Town, S Kindley Field I	tota)	~	Route Number, City
Di To the Hospital within 24 hours a To the Funeral I	Medical Ce	4 Homicide 29a. Certifier 1 Certifying	Physician: To the xaminer: On the bas	sis of examination	edge, death occurred and/or investigation,	at the time, date in my opinion, o	e and place, and death occurred	d due to the caus	e(s) and manner	as stated	
To the within To the comple	Med	29b. Signature and title of certi	and manne	er stated.		29c. License	number	<u>.</u>	29d. Date sign	ed (Month	
		30. Name an seddress of pers	on who completed of	cause of death (Ite	em 23a)	O.C.M	1,⊏.		January 7,	2010	
		Melissa Brassell, Mi	O Assistant I	Medical Exam	iner 111 Pen		altimore, MD	21201			
St Regist	ate trar	18 1 4	2010	Registrar's Sign	ure park	7					

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10e, perFH, G899, 1/7/2010, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1000 AM **ISRAEL** JANUARY 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMOR E SINAT HOSPITAL OF BALT7 MORE N/A If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number 6 Sex **Funeral** Hours 1 🗆 M 2 💢 F Days Min. Country) 0170771918 MD 91 217-07-0551 **Director** Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 X No BALTIMORE BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe #505 Funeral 21209 USA 7203 ROCKLAND HILLS DRIVE, Page 1 and 2 should be filled within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 【 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME nd Mental Hygier marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ HIBERMAN WASSERMAN anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 9930 SHERWOOD FARM ROAD, OWINGS MILLS, MD 21117 MARSHA KESSLER / DAUGHTER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of I
Important: If ite
any injury or ot BETH TSAAC ADATH ISRAEL 1 X Burial 2 Cremation 3 Removal from State 1/6/2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD. 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Renal failwel Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Congestine tallure Reard Sequentially list conditions, Examine Dua to (ur as a consequence o if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Yes 2 No ed by the a detached f 9 Unknown iis certificate has been signed by i director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Aostic Stenesin 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death? 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) MBBS RES January 600 4,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAT HOSPITAL OF BALTIMORE, 2401 W. BELVEDEREAVE, BALTIMORE MD21213 31. Date filed (Month, Day, Year) RAJEEV GUPTA 2. Registrar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Margaret Jean Kinch 10:15 PM Jan 1, 2010 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Columbia Howard 10675 High Beam Ct. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days (Month, Day, Year) 1 □ M 2 😿 F 228-78-7493 Months Hours Director 58 MA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 10675 High Beam Ct. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. <u>Ş</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Microbiologist Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Patrick Rothamel Elsie Veronica Pappas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Kinch Spouse 10675 High Beam Ct. Columbia, MD 21044 20a. Method of Disposition
1 Deurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Jan 08, 2010 len Burnie, MD Atlantic Crematory, LLC Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Part 1 Seter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 4 Pregnant Pregnant at time of death signed by the at Id be detached for Yes 1 ☐ Yes 2 ₺ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hours after death. uneral Director: After this certificate has autopsy performed page 2 1 ☐ Yes 2 ☑No 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2,400 Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined within 24 hours a To the Funeral To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 04 2010 son who completed cause of death (Item 23a) (Type, Print) 9 Portugue Pil 11055 31. Date filed (A 82. Registrar's Sig State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20a-c per fh 9900 2-2-10 vt State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Tan 2 Philistin Year **Physician** Larose 2218 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HOWARD COUNTY CENERIAL "ol umbiA 40WHRO 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 💢 M 2 🗆 F 220-15-1621 Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified ■ Director HOIDAK 1 Yes 2 No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? death with 21046 HAIT! Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2√No Specify. Specify: BLACK <u>Ş</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 th and Mental Hygiene. 7 is marked other than "n. RESTAURANE Elementary/Secondary (0-12) College (1-4or 5+) OUSEKEEPER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LAROSE AN TO INISE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. MROSE-SOM ROWN ST. 4 Date 20a. Method of Disposition 20b. FGo bilinbition Memor Park 20c Location - City or Town, State Columbia, Md. 1 Burial 2 ☐ Cremation 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensis 10220 GUILFURIL R 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPTIC Shock disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed Staphylococcal pactere mia physician and the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) the 1 ☐ Yes 2 ☐ No. detached 9 Unknown à signed by be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Rina 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen Cardiomyoputhy 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 s 24a. Was an autopsy unellitus performe certificate Diabetes Division of Vital 1 ☐ Yes 2 PNo 1 ☐ Yes 2 ☐ No After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural hours after death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the F 29b. Signature and title of peraffier 29c. License number 29d. Date signed (Month, Day, Year) JAN 2, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Boyce Howard General 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Date C. Month 3. Time of Death Day 2010 **Physician** John Peter Markus /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hartard Lorien Nursing Home Bel Air 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Min. 1⊠ M 2□ F Days Hours Director 217-18-1368 March 3, 1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h County 28a-f show th and Mental Hygtene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evandant or must be rediffed at 1 □Yes 2 No Director MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with Funeral 1909 Emmorton Road #227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11, Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐Yes 2 1 No Specify. Completed by 3X Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 U. S. Postal Service Letter Carrier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Fiscus Peter Markus ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traionce. Donna Markus Daughter South Tollgate Road; Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 1/6/2010 Glen Burnie, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Service Licensee Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catonsville, Part 1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease Immediate Cause (Final Physician ACUTE MYOCARDIAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of): Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed certificate 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred spital or Attending P nours after death. neral Director: After t y filled in by the funer 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 29a, Certifier 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) ayam 145344 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 622 S. UNION AVE HANREDE

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 2010 John Wilmer Murray BUNGA /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner TIMORE OWY If Under 8. Date of Birth (Month, Day, May 29, 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Hours Yrs 92 Maryland May Director 218-10-8470 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State fshow be filed within 72 hours after death with the Marylan ntal Hygiene.

3d other than "natural", or items 23a or 28a-f show event, the "notes! Faminer must be notified at event, the "notes!". 1 ☐ Yes 2 X No Director Catonsville MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 719 Maiden Choice Lane 21228 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White WWII Specify: \$ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Installer Telephone Company 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Is marked John G. Murray Rose E. Mullinix 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a permit. Pages 1 and Department of Health Important: If item 27 any injury or other tonce. Son 3604 Scheel Drive; Ellicott City, MD 21042 <u>David Murray</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem. Garden 1/9/2010 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Service Licensee Funeral Home of Catonsville, Inc. 630 Edmondson Avenue; Catonsville, MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** disvascu Jears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to for as a consequence of Examine signed by the attending physician and be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ⊒Yes 2 □ No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 2 No 3 Probably 4 donknown 1 ☐ Yes been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy perform certificate 1 □ Yes 2 2 🗹 No To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 1 10 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

State Registrar Name and addres

DHMH 17 Rev 1/2001

person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Peter John Moralis January 2010 11:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 400 Symphony Circle Apt. Hunt Valley Baltimore 264A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, Year, 29 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days Hours 220-20-3302 1 ☑ M 2 ☐ F 80 Months Greece **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Eventuals. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Hunt Valley Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Symphony Circle Apt 264A 21030 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2X No Specify: White ⋧ Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Union 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Peter Moralis Georgia Apostolides ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constantine Moralis / Son 400 Symphony Circle Apt 264A Hunt Valley, MD 21030 20b. Place of Disposition (Name of Greek Cemetery or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/8/2010 Woodlawn, Maryland 21. Signature of Fureral 22. Name and Address of Facility ervice Licensee 21204 Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 23a. Part 1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final Physician 4 cute MYDO disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). burial-tran and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the a detached f ☐Yes 2 ☐ No 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 s been si should t 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas page 2 autopsy performed? Yes 2 No 1 □Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2X No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one)

541

law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

State Registrar

29b. Signature and title of certifier

Evangelos

7801 York Road Suite 102 Towson, Maryland

29d. Date signed (Month. Dav. Year) January 4, 2010

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

Lignos

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 2:00P M Edward A. Meekins 2010 January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner 1308 Gateshead Road Towson 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2 □ F Min 2427. 14927 82 220-18-4435 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director MD Baltimore Towson 1 ☐ Yes 2xxNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō if of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be or other traumatic. 21286 Funeral USA 1308 Gateshead Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give ₩₩ T T 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Year or Dates. WWII Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) E.C. Meekins & Sons Storage 12 Moving / Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be filed ည Frances Silka Ethridge Meekins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1103 Walnutwood Road Hunt Valley, MD 21030 19a. Informant's Name/Relationship (Type, Print) Debra A. Moy / Daughter Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a Department of H Important: If ite any Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □XOther (Specify) Entombmen t Dulaney Valley Mem. 1/8/2010 Timonium, Maryland 22. Name and Address of Facility Towson, Maryland 21204 21. Signature of Funeral Service Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mellel Pnysician/ DIABETES disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Due to (or as a consequence of) requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregrant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available 24a. Was an Hospital or Attending Physician: The law 124 hours after death.
 Funeral Director: After this certificate has b prior to completion of cause of death? autopsy performed cate has page 2 s 1 Yes 2 No Yes 2 No 26. Place of Death (Check only one) Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ER/Outpatient 3 DOA ည 1 Inpatient 2 I 27. Manur of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29d. Date signed (Month, Day, Year, 29b. Signatur and title of certific

30 T

Registrar

DHMH 17 Rev 7/2009

30. Name and address of person

31. Date filed (Month, Day, Year)

Haber

JAN 0 7 2010

Craig

Charles Street Suite 410 Towson, MD 21204

who completed cause of death (Item 23a) (Type, Print)

6535

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical City, Town, or Location of Death 4a. Facility Name (if not institution, **Examiner** edica enter Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🖳 M 2 🗆 F iul 10. 1932 357-22-2412 78 Director Il Tinois Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at **Funeral Director** 10d. Inside City Limits York Shrewsbury 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? other traumatic event, the Medical Examiner must be 23aU.S.A. 107 Strassburg Circle 17361 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No
If Yes, Give 52 52 155 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ō ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 → Yes 2 □ No Specify: Mexican 'natural", 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Shipyard Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Orozco Margaret House 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 107 Strassburg Cir., Shrewsbury, PA 17361 Jean Orozco-wife If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State St. John the Baptist 01/09/2010 injury or permit. Page Department Important: If any injury or once, New Freedom, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Box 68760 If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 → No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 🗆 Pending work? To the Hospital or Attendin within 24 hours after death.

To the Funeral Director; Aft completed filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

DHMH 17 Rev 7/2009

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4:34 PM JaNuar 03 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital Baltimore City 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Days 1 M 2 F Yrs 216-34-2397 71 Jan.4,1938 MD **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone. 10c. City, Town or Location 10d. Inside City Limits 10b. County ¹ X Yes 2 □ No Director n/a MD Baltimore 10f. Zip-Code 10g, Citizen of What Country? 10e. Street and Number 1817 N. Caroline St. USA Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify Specify: black ò 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Nurse's Assistant Rosewood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Carter Margaret Carter ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter Richardson Bernadette D. 1817 N. Caroline St. Balto, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Jan.12,201|0 onation 5 Other (Specily) Garrison Forest Vệt OwingsMills, Signature of Funeral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 F P
Do not enter the mode of dying Preston St. Balto, Md. 213 Approximate 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. cps15 Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician ard for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tyes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ၀ 6 Other (Specify) funeral Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: A 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signat 29d. Date signed (Month, Day, Year)

Date filed (Month Day Year)

MICHAEL

Name and address of person who

32. Registrar's Signature

pleted cause of death (Item 23a) (Type, Print)

A. Marie

State Registrar RES-000

2010

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** January VERDA MARLENE ROTH 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital of N/A Baltimore Date of Birth (Month, Day, Year) 04/06/1933 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 💢 F 402-40-2965 76 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, The Madical Extrainer, 1911 be notified at 1 ☐ Yes 2 X No Director MD BALTIMORE PIKESVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 USA 3215 NORTHBROOK ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 X No \$ 3 X Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER** TRANSPORTATION 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be JAMES GOLDEN JOHNSON LILLIAN STEWART 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SHARON LEVINE / DAUGHTER 3215 NORTHBROOK ROAD, BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 🛱 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/6/2010 CINCINNATI, OH CHESED SHEL EMMES 21. Sign ture of Funeral Service kicens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami burial-tran physician at the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) ☐Yes € No 9 I I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 ☐Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To After this To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 ES - 000 address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Dellakas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Months Davs Hours 1**√** M 2□ F Min 51 217-70-0110 Director 15 58 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at MD N/A Baltimore Director 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1366 Pentridge Rd 21239 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Bace - American Indian African 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other this any injury or other traumatic event, I'm once. Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Douglas T. Ross, Sr. Anna J. Lewis ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle A. Morgan/Sister 1366 Pentridge Rd, Balt., MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Pk 1/8/10 Balt. County,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. Close F. 21. Signatural of Funeral Service Licen 5126 Belair Rd, Balt., MD 21206-5105 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. NON Ischemie Cardiamyafathy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any bearing to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 2 1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, the signed by t I be detach page 2 should has certificate director, After 1 within 24 hours after death.

To the Funeral Director: A

completely filled in by the fu

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a, Certifier

(Check only one)

and title of certifie

Name and address of perso

31. Date filed (Month, Day, Year.

who completed cause of death (Item 23a) (Type, Print)

S Greene 32. Registrar's Signature RIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 81.30AM 2010 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Himore If Under 24 Hrs 25 N/A Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 27 29 224-32-8731 1 M 2 D 80 Director NC Usual Residence of Decedent 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director N/A MD Baltimore 1 🎦 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 525 Presstman St. 21217 USA be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black. White, etc þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 African Amer. If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Self Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 12 Be 17. Father's Name (First, Middle, Last) 8. Mother's Name *(First, Middle, Maiden Surname)* Maude Ingram Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic ever J.B. Stokes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 525 Presstman St., Balt., MD 21217 Raymond Smith/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other plant. Zion Cem matory or other place) 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State 1/9/10 Balt.,MD Mt. 4 Donation 5 Other (Specify) 22. Name and Address of FacilityHari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral S-vice Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ esophageal reus disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events coulting in doubly) Lost. Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregna 5 ☐ Other (specify) Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ bivision of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 Tes 2 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 4 Nursing Home Certificate: Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident (Month, Day, Year) injury 5 Pending М 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOS7936 01-07-2010 son who completed cause of death (Item 23a) (Type, Print) 22 S. Oreene St Bartmar, Mb 21201.

State Registrar

DHMH 17 Rev 7/2009

32. Registrar's Signature

## Baltimore, Maryland 21215-0036

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Funeral		5. Social Security 1	Number	6. Sex		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birt	hplace (State or Forei untry)	gn
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permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. I minortant: If time 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, I a Medical Examiner must be notified at once.			•	3 🗆 Removal from			osition (Name of matory or other plac urney Crei		<sup>2010</sup>		ation - City or Bbine,	,	
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To the Hospital or Attendin within 24 hours after death To the Funeral Director: Aft completely filled in by the fun		29a. Certifier (Check only		ng Physician: To th Examiner: On the									
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11		30. Name and add	Iress of person	who completed cau	se of death (Ite	em 23a) (Type.	Print)				7		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2.50 AM uant Leonar anuary 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Buznie Raltimore Washington Medical ANNE HRUN DE Glen If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Social Security Number 9. Birthplace (State or Foreign Country) BGIT IMSE | MD 7. Age (In vrs. last birthday) **Funeral** If Under 1 Year -94-0255 Director 39 or 28a-f shov 10a, State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21113 APT# 202 2011 Sintry USA 12. Was Decedent Ever in U.S. Armed Forces? | 10/10/87 1 A Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Specify: Black Year or Dates. 3/3/94 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2th Grade Computer Federal Government Be **Maryland** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) STOKES Kather inc Hoggard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mo thei Kutherine O MAQUITE 00tKUllvania Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale iverdale 21. Signature of Funeral Service Licensee 3HUPBNUTST. NW 1182 Services Funeral Washington 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Poset and Death Physician/ disease or condition resulting in death) Medical Due to or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the selected is 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director: After this certificate has I commissed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 힏 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge of 29d. Date signed (Month, Day, Year) 2010 0327 and address of person ho completed cause of death (Item 23a) (Type, Print) GAVIRIA 301 31. Date filed (Month, Day, Year) Registrar

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<u>8</u>	nd 2 saith ar		19a. Informant's Name/Relationship (Type. Print)  MR Carlton A. Sexton Jr./Son  19b. Mailing Address (Street and Number or Rural Route Number, City 7874 Kings Arm Court Pasadena, N										
e,	is 1 a		20a. Method of Disposition		20b. F	Place of Dispos	sition (Name of natory or other place	e) Jan	Date uary	20c. Location - City	or Town, State		
Ē	Page nent ( ant: If ury or	ļ	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State		Cremator		2010	Glen Burn	ie, MD		
Банттог	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modell Examiner must be notified at once.		21. Signature of Funeral Service	Licensge	Xlann					Funeral &	Cremation ie, MD 21061		
			23a. P. t1. Enter the disease, of	nomplications that	caused the deat						Approximate Interval Between		
	Physician		shock, or heart failure. List Immediate Cause (Final	only one cause on e	each line.		rightslA	٠. ما	Dego		Onset and Death		
	/Medical		disease or condition resulting in death)	a. Due to	(or as a conseq	uence of):	-11 ENIEV	N-6 2	13000		years		
	Examiner			-									
		١, ا	Sequentially list conditions	b									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month NUAR Pay Year Vatana Sadarananda 8:26P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Medical Center Saint 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 X M 2 - F 82 5/29 14927 That'l and 174-36-6151 Director Usual Residence of Decedent shov 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 28a-f MD Baltimore Towson 1 Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21286 items 23a Funeral 1221 Brook Hollow Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ō þ 1 Never Married 2 X Married Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 Yes 2 X No Specify. Specify: Asian "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Medical Physician Be 17. Father's Name (First, Middle, Last) 18 Mother's Name *(First, Middle, Maiden Surname)* Amnuay Lim Chareon Thong Yoo Sadaran permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1221 Brook Hollow Road, Towson, MD 21286 Doretha Sadarananda/ Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Hilltop Service Corp. 1/07/2010 1 

Burial 2 

Cremation 3 

Removal from State Towson, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIAC ARRHYTHMIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner MYOCARDIAL INFARCTION DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day ed by the a detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes 2 **Division of Vital** 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ၉ 1 Inpatient 2 K ER/Outpatient 3 I DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural injury 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 1 Yes 2 No Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 01,06,2010 D62551 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MARYLAND 21204 BEAUVOIS, 37. Registrar's Signat 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

JAN 0 7 2010

			Please	e Type or Print in				_		_egible.		
			For State	State of Maryla	and / Departme <i>Certifica</i>			Mental Hy	giene Reg. No2	010	0.01	70
	Physicia		1. Decedent's Name (First, Middle, L.	ene lo	aulor	210 07 2	- Culti	2. Date of De	<u> </u>	2010	3. Time of Do	
	Medio Examir		4a. Facility Name (if not institution, gl		4b. C	ity, Town, or	Location of Deat	h	4c, C	ounty of Death	1 1,000	
	Francis		5. Social Security Number 6.	Sex - 7. Age (In yr	s. last birthday) If Un	der 1 Year	If Under 24 Hrs	T	rth	9. Birthr	olace (State or F	Foreian
	Funeral Director		218-44-0567 Usual Residence of Decedent	1	Yrs. Month	ns Days	Hours Min.		Y, 194	5 Viro	ginia	
	Maryland 28a-f shootified at	Director	10a. State 10b. County	1A 10c.	City, Town or Location	ima	0			1	0d. Inside City	
	with the s 23a or 3	Funeral D	10e. Street and Number 838 N · Ew	taw Str	eet		1201			LSA	itry?	
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 Never Married 2 Married  Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 Yes 1 Yes, Give Year or Dates.	If Yes, s	cedent of His pecify Cubar s 2 July 2	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		Race - Americ Black, White, o pecify: B		ر
21215-0036	nin 72 hour ne. <b>.han "natu</b> e Medical	Completed	15. Decedent's (Specify only highest of Elementary/Seconday (0-12)	Education grade completed) College (1-4 or 5+)	life. DO NOT	work done d use retired)	furing most of wo	rking	16b. Kind	of Business Inc	)	
	ed with Hygier other t	Be C	17. Father's Name (First, Middle, Last	9 ;	Mean	aru		me (First, Middle	Maiden Su	rname)	epair	
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altimore,	age 1 ar ent of He nt: If iter y or oth		20a. Method of Disposition  1 ☐ Burial 2 Cromation 3  4 ☐ Donation 5 ☐ Other (Spe	Removal from State	b. Place of Disposition (I cemetery, crematory of	Name of or other place Made	/ 1/1	7/2010)	20c. Loca	ation - City or To	24	47
Baltii	permit. P Departm Importal any injul		21. Signature of Funeral Service Lice			and Addres		owell	Fu	resal	How	207
	Physician/ Medical		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	mplications that caused the decrease on each line.  a. MENUTE SAME  Due to (or as a cons	micer C						Approximate Interval Betwe Onset and De	ath
<b>\</b>	ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as a cons	equence of):							
250	e be executed ysician and e burial-transi	<u>a</u>	that initiated events resulting in death) Last	c. Due to (or as a cons	equence of):							
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35	Physic this ce al direc	၉	1 ☐ Yes 2 No 27, Manner of Death	Hospital: 1 Inpatient 2 28a. Date of injury	ER/Outpatient 3  28b. Time of		4 ☐ Nursing I	Home 5 Res			HOSPI	CE
Jo no	nding lath. r: After e funer	icate	1 Natural 5 ☐ Pending 2 ☐ Accident Investigat	(Month, Day, Year)	injury M	28c. Injury work 1 $\square$		28d. Describe	now injury o	ccurred		
bert Division	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Il Certificate;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		t home, farm, street, fac cify)	tory, office			Street and I wn, State)	lumber or Rural	Route Number	ŗ
3	Hospit 24 hour Funera eted filk	Medical	(Check 2 Medical Exa	nysician: To the best of my kn miner: On the basis of examina urse Practioner: To the best of	ation and/or investigation,	in my opinio	on, death occurred	at the time, date	and place, a	nd due to the ca	use(s) and mann	ner state
	<b>To the</b> I within 2 <b>To the</b> I соптре	Σ	only one) 3 L Certifying No. 29b. Signature and title of certifier	or se Fractioner: To the best of		29c, License		iace, and due to t		signed (Month,		
			I heavell of	1. Ferous	3 h	D58	3217		alo	5/201		
	V		30. Name and address of person who	o completed cause of death (li	tem 23a) (Type, Print)	250	BA	CTTUSO	RE	MD 2	128/	
	Sta Registi		31. Date filed (Month, Day, Year) JAN 0 7 20	HO Registrar's Sig	gnatife facili	9						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Physician/ 4:45 AM Carolyn Linda Trakney 01 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 219-40-4456 **Funeral** 1 □ M 2 🗓 F Months Days Min. July 26, Year 194<u>3</u> Hours Maryland Director 66 Usual Residence of Decedent permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Marken. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h County Director 1 Yes 2 K No Dorchester Cambridge MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21613 601 William Street Apt W2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Completed by Baltimore, Maryland 21215-0636 White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail <u>Distributor</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin Britenbach Lillian Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Buenevista Avenue; Cambridge, MD 21613 Nancy Windsor Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Glen Burnie, MD 1/10/2010 Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service densee 4104 MO1537 1630 Edmondson Avenue; Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CARCINOMA Physicianz disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to for as a consumuence of than y leading to immedicause. Enter Underlying Cause (Disease or iinjury cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death q Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 Yes 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? 2/ No Hospital Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Doth 28a. Date of injury (Month, Day, Year) 28b. Time of the funeral 28c. Injury at 28d Describe how injury occurred work?
1 \( \sum \) Yes 2 \( \sum \) No Natural iniurv 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and fitle of certifie 29c. License number 29d. Date signed (Month, Day, Year) 005 8410 Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 SACI BURY PU Humm 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Van Kirk Danuciru 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kuntephysician: Vantirty, Henry VA Maryland Health Care
5. Social Security Number 6. Sex erru Date of Birth (Month, Day, Year) if Under 1 Year Birthplace (State or Foreign Country) (In yrs. last birthday, **Funeral** 1∭M 2□ F 212-05-2465 Director 06-06-1914 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Evaminer must be notified at Director 1 ☐ Yes 2 ☐ No Odenton MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

The marked other than "natural", or items 23a or in injury or other traumatic event, the Madical Exprisive matthem. 21113 U.S.A. Completed by Funeral 1212 Odenton Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Auto 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nevada Whipple Van Kirk Alice William 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Veronica Hartley /Daughter 1058 Omar Drive Crownsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01-12-2010 MD Veterans Cemetery Crownsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 1 2nd Avenue SW 21. Signature of Funeral Service Licenses Glen Burnie, MD lattle 1 4 MO1580 Singleton Funeral & Cremation Services, PA 23a. art 1. Enter the disease, or o' implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month 5 Other (specify) P.0. ☐Yes 2☐No 9 Dunknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? certificate 2**X**No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27, Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director; in by the 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

X

San Z

State Registrar amanyland Health Care System, Perry Point, MD 21902

wills 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marcal Walton 10-00066 **UNK UNK** 

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2010 00173

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State of Maryland /	Department of He	ealth and Menta	al Hygiene

		1- For State Registrar	Ce	ertificate	e of Death	10 111011	R	eg. No.	0 0017
Physici edical Exam		n/ 1. Decedent's Name (First, Middle,Last)					Date of Dea     Month	Day Year	3. Time of Death
Sulcai Exami	mer	Marcal Antwan  4a. Facility Name (if not institution, give street and number)			Walton  4b. City, Town, or Location of Death			, 2010 4c. County of Dea	1520 hrs
		2300 block Ocala Av	enue		Baltimore			N/A	
Funeral		5. Social Security Number	6. Sex 7. Age (In yrs	s. last birthda	Months Da		Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. B Fore	
Director		212-88-4150	1 M 2 F	33	Yrs.	, riodis	11/1	1/1976 °	ountry) MD
any		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ity, Town or I	_ocation				10d. Inside City Limits
and show	٦c	MD	N/A	Balti	more				1 X Yes 2 No
th the Maryland 23a or 28a-f show any notified at once.	Director	10e. Street and Number	,		10f. Zip Code	*	1	0g. Citizen of What Co	untry?
th the 23a or notifie		2208 Penrose			212			U.S.A.	
eath w items ust be	uneral	11. Marital Status  1 Never Married 2 X	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No		<ol> <li>Was Decedent of H</li> <li>If Yes, specify Cuba</li> </ol>			- 14. Race - Ame White, etc.	rican Indian, Black,
after d al", or	by Fu	3 Widowed 4 Di	1 Yes 2 No		1 Yes 2 X N	o specify:		Specify: B	lack
hours natur			ecify only highest grade completed)		edent's Usual Occupa ng most of working lif			16b. Kind of Business	/Industry
36 hin 72 e. than "	Completed	Elementary/Secondary (0-12)	) College (1-4 or 5+)		Self			Car Wash	n
215-0036 be filed within 72 ntal Hygiene.	Con	17. Father's Name (First, Middle	e, Last)		DCII	18.Mother's Na	me (First, Middle, N		
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	) Be	Nathaniel 19a. Informant's Name/Relation	ohio (Timo, Print.)	Walt		Demea		hornton	7 0 11
and 2 should realth and N tem 27 is n traumatic	To	FaShaunDa Wa						, MD 2122	
		20a. Method of Disposition  1   S   Burial   2   Crematic	20b	D. Place of D	isposition (Name of co		Date	20c. Location - City o	
imore Pages I nent of H ant: If it	5	4 Dopnation 5 Other S		,		ery 01	/12/10	Baltimo	re,MD
Baltimore, permit. Pages 1 ar Department of Her Important: If ite injury or other tr		21. Signature of Funeral Service	e Licensee		22 Name and Addres	s of Facility Brow	n Jr. F	uneral Ho	ome
Physician			r complications that caused the deal	th. Do not er				alto., MD	21217 Approximate Interval
// /Medical Examiner	1	failule: List only one cause Immediate Cause (Final disease	A A 10'-1 O 1 1 1 A /-	unds					Between Onset and Death
Ladiiiiici		or condition resulting in death)	Due to (or as a consequence	of):					
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ecuted and transit			d						
sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed death.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit	Medical	UNPENDED	AMENDED						
876 rtificate ing phy as the		IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	he 23c. If yes, outcome of pre	egnancy 2	Fetal death 3	Ectopic preg	nancy	23d. Date of deliver Month	y Day <b>Y</b> ear
Box 687 ne death certific the attending I	sician		4 Pregnant at time of conknown	death 5	Other (Specify)				
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ion (tendin eath.	Certification:	1 Natural 5 Pen 2 Accident Inve	ding FOUND: Day, Year) stigation Jan 3, 2010	FOUND 1513 hrs	1 1	Yes 2 V No	Subject shot		
Division tal or Attendir is after death.  al Director: A led in by the fu	tifica	3 Suicide 6 Cou	ld not be 28e. Place of Injury - At	home, farm,		building, etc.	or Town, St	tate)	ural Route Number, City
Division  To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	S	29a Certifier	(Specify) Local Stre		accurred at the time of	late and place a		Ocala Avenue, Balti	
o the Pithin 24	Medical	(Cricon Crit)	aminer:On the basis of examination and manner stated.	_				,	
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<b>D</b>		NLMUL	1 mp		0.0	M.E.		January 4, 2010	
30		<ol> <li>Name and address of persor Donna M. Vincenti, M</li> </ol>	n who completed cause of death (Item D Assistant Medical Exa	,	111 Penn Street	, Baltimore.	MD 21201		
	9.60	31 Date filed (Month, Day, Year)	37 Registrar's Signa						
Regist	_	JAN 0 7	2010 Lever &	1. 194	alle!		<del></del>		
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ilgela vvileele		1- For State  Certificate of Death  Registrar  Reg. No. 20 10 00	174
Physici ledical Exami		1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year	
icaicai Exam		ANGELA WHEELER  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	
		St. Agnes Hospital Baltimore	
Funeral Director		5. Social Security Number 217-86-1437  6. Sex 1 Months Days Hours Min.  7. Age (In yrs. last birthday) 1 M 2 Yrs.  7. Age (In yrs. last birthday) 1 Months Days Hours Min.  8. Date of Birth(MM/DD/YYYYY) 9. Birthplace (Stat Foreign Country) MIN.  1 Months Days Hours Min.	
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside	City Limits
<b>*</b>	or	5 MD BALTIMORE 1 X Yes	2 No
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
with the IS 23a c	ral D	5 2737 EDMONDSON AVENUE 21223 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, E	Black,
21215-0036 Id be filed within 72 hours after death wirental Hygiene. narked other than "natural", or items event, the Medical Examiner must be	Funeral	1 X Never Married 2 Married 2 Armed Forces? 1 Yes 2 No White, etc.	
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6 72 hou in "nat	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)	
5-0036 iled within 72 Hygiene. I other than the Medical	omp	HOUSEKEEPER HEALTH  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
21215- uld be filed Mental Hy marked of	ВеС	10. Mouter's Name (First, Middle, Last)	
14 3 ~ = 0	To	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
and 2 sho and 2 sho Tealth and trem 27 is		DELORES WHEELER/MOTHER 2737 EDMONDSON AVE. BALTIMORE, MD 21223  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	
Baltimore, Department of Hee Important: If ite		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:  BALTIMORE CREMATION CIR 1-7-10 BALTIMORE, MD	
Saltir emit. I epartm n porta jury ou		21 Signature of Funeral Service Licensee  22. Name and Address of Facility JAMES A. MORTON & SONS F.H	.,inc.
Physician	- 1	23a Part I. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximately	ate Interval
Medical		failure. List only one cause on each line,  Between	Onset and eath
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OX 6876 eath certificate attending phy for use as the	ician/M	FFEMALE: 23c. If yes, outcome of pregnancy 1	Year
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Vital hysician: this certif	o Be	examiner?  1 Ves 2 No  Hospital. 1 Inpatient 2 ER/Outpatient 3 DOA  Other Nursing Home 5 Residence 6 Other:	
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Division tal or Attendi rs after death at Director: //	ertification	Pending  Accident Investigation  Accident Investigation  28e Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number or Rural Route Number or Rural	imber City
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To To the comp	Medical	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Yea.	r)
1 .		O.C.M.E. January 6, 2010	
oknerd.		30. Name and address of person who completed cause of death (ftern 23a)	
Λ, λ	ata	Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date file No (p. pay 200)  32. Registrar's fignature	
\ S	ate	31. Date of the pay and 32. Registrar's signature	

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within 24 hours and the Funeral completely filled	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated.  29b. Signature and title of certifier  29c. License number						opinion, death occ	occurred at the time, date and place, and			e to the cause(s)
within 24 hours after death.  To the Funeral Director, After completely filled in by the funeral process.	al Certification:								s stated.			
death. ctor; After th y the funeral		2 Accident investigation M					28c. Injur Wor 1 🗌		28d. Describe how injury occurred			
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		25. Was case referred to medical						26. Place of Dea	auto perf 1□ Yes	ormed2 2 No	death?	topsy findings avail completion of cause 2 ☐ No
seen sign	eted by		1 ☐ Yes 2 ☐ No									
by the ached	/ Physician/Medical	230. Was december pregnant in the past 12 months?   1 □ Ive birth   2 □ Fetal death   3 □ Ectopic pregnancy   5 □ Other (specify)   9 □ Unknown   9 □ Unk						23e. Did		Month	Day Year	
attending physician and for use as the burial-transit	n/Medical	IF FEMALE: 23b. Was decedent pregnant	d23c. If yes, outcom	ne pf pregna	ancy					1	23d. Date of del	ivery
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permit. It ages I am a Department of Health a Important: If Item 27 is any injury or other tra		1 ☐ Burial 2 ☐ €remation 3 4 ☐ Donation 5 ☐ Other (Spe	ecify)		enmou	ınt	Ceme	etery1-				,Maryla
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nd Mental Hygiene. marked other than imatic event, the Me	ø	17. Father's Name ( <i>First, Middle, La</i> William Whitne	,					18. Mother's Nar Marie	ne (First, Middle	e, Maiden	Surname)	
ygiene. er than " t, the Mec	Comp	Elementary/Secondary (0-12)	College (1-4or	r 5+)	Crair			tor			hlehem	Stee.l
"natura	oleted	15. Decedent's (Specify only highest	grade completed)		16a. Deced	lent's Us kind of w	ual Occup ork done use retired	oation during most of wo	rking	16b. K	ind of Business/	Industry
popularies, agon to Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3X Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 HYes, Give Year or Dates	?			edent of Hecify Cuba 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	0-	14. Race - Ame Black, White Specify: B1	
ems 23a or 28a-f show	al Dìre	10e. Street and Number 3600 Anne - Hat		Αr	ot.3B	10f. Z	ip Code			10g. Cit	izen of What Co USA	
a-f shov	ctor	10a. State 10b. County  Maryland Balt	imore		ndalls		m					10d. Inside City L 1 ☐ Yes 2
Director		219-14-2101 Usual Residence of Decedent	8	5-84	y, Town or Lo	nation			Apr.	2,1	<del>924</del> Ma	ryland
Funeral	22	Social Security Number     6		age (In yrs.	last birthday) Yrs.		er 1 Year		8. Date of Bi	rth		hplace (State or Fountry)
Examin	- 0	4a. Facility Name (If not institution, g		r)				r Location of Deat	h		County of Deat	
/Medic		Raymond Whit	ner						Jan.	3, Da	2010 <sup>Year</sup>	5:40A
Physicia		1. Decedent's Name (First, Middle,	Lasi)					Ensure A 10 yt lealth and 372010, ws Death	Z. Date of De	eatn		3. Time of De

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Philip Ben Wah, Sr. January 5, 2010 Year Physician/ 7:30 A M Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore 2835 Quarry Heights Way If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Days Hours Min. 217-20-4737 86 <sup>c</sup>Maryland 9 Marth Par23" Director Usual Residence of Decedent 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🗌 Yes 2 🙀 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2835 Quarry Heights Way 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Ⅸ Yes 2 ☐ No If Yes, Give Year or Dates. WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than matic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Dry Cleaning 12 Dry Cleaner Mental Hygier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev pe 1 Chin Foy Wah Louise Shee Wah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Wah / Son 404 S. Prospect Ave. Manhattan Beach, CA 90266 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Serv. Corp Date 20c. Location - City or Town, State 1 Durial 2 Dremation 3 Removal from State 1/11/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 21. Signature of Funeral Service Licenses Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician CANCEC COLON MOS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or impury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Kidney Concer 2 No 3 Probably 4 Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prostate concer has autopsy page death? certificate I budde conce 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 →No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending after death. 2 Accident Investigation the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the lawithin 2 To the law 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) 5 MD 110 038709 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Willer Sharran 10753 12115 Ra #415 Limile 10 21093 31. Date filed (Month, Day, Year) 32: Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1:00PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1309 Morling Avenue N/A Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Funeral **X** M 2□ F 216-62-1725 54 Director May 18, 1955 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at 1XXYes 2 □ No Director N/A Baltimore Md 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with 1 Health and Mental Hygiene. 9m 27 Is marked other than "natural", or items 23a or 3 1309 Morling Avenue 21211 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Yo 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married XX Married 1 ☐Yes 2 ☐X If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 1 □ Yes 21√10 Specify Specify: White ۾ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dry Wall Refinisher Acropolis 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Young, Jr. Katherine Brown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 Is any injury or other trau Janet Young (Wife) 1309 Morling Avenue Balto, MD 21211 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 ☐ Burial 2 ☐ Gremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Atlantic Crematory 1/6/10 Glen Burnie, MD 22. Name and Address of Facility Burgee-Henss-Seit 3631 Falls Road z Funeral Balto, MD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical as the IF FEMALE: asn yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a d be detached for P.O. I □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death t tanot resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be rector, page 2 s autopsy performe 1 Yes 1 ☐ Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 \sum Nursing Home 1 ☐ Yes 24 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

21

State Registrar

DHMH 17 Rev 1/2001

JAN 0 7 2010

31. Date filed (Month, Day, Year)

30. Name and address of person who completed



of death (Item 23a) (Type, Print)

ORIGINAL

10-00011 Seung Kab Yoo

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

eurig Nab 100		1-For State Criticate of Death Registrar		a. No. 201	0 00170	
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month January 1,		3. Time of Double 1105 hrs	
neulcai Examii	lei	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dea	January 1,	4c. County of Deat		
		10676 Hillingdon Road Woodstock		Howard		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24I Months Days Hours N  Usual Residence of Decedent	Ars. 8. Date of Birth	(MM/DD/YYYY) 9. Bit Foreign	thplace (State or gn South bountry)	
Maryland <b>28a-f shnw any</b> <u>d at once.</u>		10a. State 10b. County 10c. City, Town or Location WOODSTOCIC			10d. Inside City Limits 1 Yes 2 No	
death with the Maryland nr items 23a nr 28a-f shu must be notified at once	Dire	106.76 HILLING DON ROAD 21163			S A	
fter death wi	Fune	1 Never Married 2 Married Armed Forces? 1 Yes 2 No  No. 2 No		14. Race - American Indian, Black, White, etc.  Specify: ASIAN		
2 hour	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)		16b. Kind of Business/		
		17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)	me (First, Middle, M	aiden Surname)	/	
2121 hould be fi and Mental is marked stile event,	To Be	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number of	or Rural Route Numb	er, City or Town, State	e, Zip Code) 22043	
MC 2 s alth at alth at are 27 reum.		JANICE JOCI-PAUCATER   6449 DRRELL-2   20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   1	Date	20c. Location - City or	Town, State	
Baltimore, permit. Pages I a Department of He Impartant: If ite	ŀ	4 Donation 5 Other Specify:  21. Signature of Puneral Service Licenses  22. Name and Address of Facility				
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.			Approximate Interval Between Onset and	
/Medical Jaminer		Immediate Cause (Final disease or condition resulting in death)  a. Hanging  Due to (or as a consequence of):			Death	
	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
uted nd ransit	Ш	(Disease or frjury that initiated events resulting in death) Last Due to (or as a consequence of):  d.				
be exectivities as incian as unial - t	Medical	☐ UNPENDED ☐ AMENDED				
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the buriat - transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 4 Pregnant at time of death 5 Other (Specify)	gnancy	23d. Date of deliver Month	y Day Year	
P.O. Box		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to		
S, P.C uires that n signed t	ed by				bably 4 Unknown	
24a. Was an autopsy performed? 1 Yes 2 V No 1 You death?  25. Was case referred to medical examiner?  1 Yes 2 No 27. Manner of Death  26. Place of Death (Check only one)  27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?  28b. Describe how injury counted (Month, Day Year)						
of Viting Physic	၂၉	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		esidence 6 🗹 Othe	r: Scene	
ion of Vital   trending Physician: teath. ther: After this certification;	ation	1 Natural 5 Pending Jan 1, 2010 0000 hrs 1 Yes 2 V No	Subject han			
Division pital nr Attendii wus after death. eral Directur. /	Certification	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Single Family	28f. Location (Street and Number or Rural Route Number, City or Town, State) 10676 Hillingdon Road, Woodstock, MD			
	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a core)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.				
F 3 F 8	ž	29b. Signature and title of certifier  29c. License number  O.C.M.E.		29d. Date signed (Mo		
61	-	30. Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	<u>_</u> D 21201			
Sta	ate					
Registi	rar	JANU7 ZUTU KENUL B. Januar				

C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day Andrews Μ. John January 2010 6:57 a. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges 6400 Muirkirk Road Beltsville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 1 **∏** M 2 □ F Hours Mar 8 Days Min. Year 951 Maryland 58 Director 212-58-7755 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Prince Georges Beltsville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 20705 6400 Muirkirk Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🗽 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Universities Grounds Landscape Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Jane Kibler John W. Andrews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6400 Muirkirk Rd. Beltsville, Maryland 20705 Lucinda Keppel (Pers. Rep.) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 8 20c. Location - City or Town, State ☐ Burial 2 I Cremation 3 ☐ Removal from State Chesapeake Crematory Beltsville, MD. 4 Donation 5 Other (Specify) 2010 Sign e of Paniral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Ave. Silver Spring, Maryland 20910 M00982 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1/2009-2010 Immediate Cause (Final Physician/ Metastatic Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Lause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl autopsy perform 2 🗌 No Yes 2 X No 1 Yes 25. Was case referred to medical funeral director, To Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work' ours after death. eral Director: Aft filled in by the fur 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier D0066419 January 7, 2010

Registrar
DHMH 17 Rev 7/2009

State

Registrar's Signat

20723

Name and address of person who completed cause of death (Item 23a) (Type, Print)
 Prema Siv, 8871 Gorman Rd., Laurel, MD

31. Date filed (Month, Day, Year)

JAN 0 8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 3, 2010 Year 5:25 P M GEORGE WALTER ALSFELD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day 1 🛛 M 2 🗆 F Months Days Hours 1957 Rhode Island Director Jàn. 035-38-1811 52 Usual Residence of Decedent 10b. County 10a. State with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Marvland | Harford Abingdon Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21009 3233 Stone Eagle Court USA death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give 1 Yes 2 X No Specify Completed 3 Widowed 4 Divorced White Year or Dates If item 27 is marked other than "nature or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha Chemical Engineer Chemical Manufacturer 5+ Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leonard (unk) Alsfeld Margaret (unk) Schneider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Alsfeld 02919 <u>/ Sister</u> Cinnamon Dr.. Johnston, RI Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Rer Other (Spec St. Ann's Cemetery 1-8-2010 4 Donation Cranston, RI 21. Signature of Fund McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the "sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ a RENAL CANCER disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Dua to (or as a nonsequence of): if any, leading to immediate cause. Enter Underlying the attending physician and hed for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? Director: After this certificate has perform 2 🗌 No 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. δθαν. .... 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? Hospital Other: ဥ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a who completed cause of death (Item 23a) (Type, Print) JONES, CRNP 2300 DULANEY VALLEY RD. JACKIE TIMONIUM, MD 21093

State Registrar

5:25

JANUARY

GEORGE ALSFELD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 9.00 A M BRADER JOSEPH 10 0 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore Rossville Manor Care -Rossville If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours Months Days 1**3** M 2 □ F 212-28-1215 78 March 9,1931 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Harford Belair 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21015 USA 1122 Royston Place 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∐ Yes 2 12 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Pull & Kent Co. 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pauline Hoffman Joseph Brader 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1122 Royston Place Belair MD 21015 Joseph E. Brader /son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory 1/6/10 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a co equence of): Accident Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last dimyoz Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a, Was an autopsy performed? Yes 2 10 1 ☐Yes 26. Place of Death (Check only one) Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mipletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Funeral

Director

show

MD

d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event. The Market and Once.

Physician /Medical **Funeral Director** 

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death with the Maryland

Medical Certification: To Be Completed by Physician/Medical Exami
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and
To the Hospital or Attending Physician; The law requires that the death certificate be executed

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25.	Was case re examiner? 1 Yes		to medical
7	Manner of D	eath	

1 🖳 Natural 2 Accident 3 Suicide determined 4 Homicide

29a, Certifier

5 Pending investigation 6 □Could not be

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28c. Injury at Work? Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier (

29c. License number MD 31464 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EUTAN S+ Suite 308 BALTIMORE MD 21201 HASHMI MD.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Doris Buccheri 8:30 A M 2010 Tanuary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Days (Month, Day, Year) Feb. 7. 1918 Months Hours 1 M 2 7 F 91 215-03-4621 Maryland Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City. Town or Location Director MD 1

Yes 2 □ No Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S A. Funeral 21214 3022 Pinewood Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White Specify: 3 X Widowed 4 □ Dîvorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Victor O'Farrell Reva Shipley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr Department of Health an Important: If item 27 is any injury or other trau Thomas Buccheri/ Son 8503 David Avenue, Baltimore, MD 27234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Holy Redeemer
Cemetery 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 01/12/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility | Chapel & Cremation Services | 8800 Harford Rd. Parkville, MD 21234 21. Signature of Funeral Service Licenses Wikalli 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or that failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Ph, sician/ Chroni disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Day 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \sum \) Nursing Home 5 \( \sum \) Residence 6 \( \frac{\text{th}}{2} \) Other (Specify) 2 X No ٩ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No M 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CRNP R149194 Janhery 2010

Registrar
DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Januar 59PM 7010 Medical Facility Name (if not institution Examiner 4c. County of Death MOV . Social Security Number 8. Date of Birth 09/19/19/19/39 If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Days **XX** M 2 □ F Hours 153-30-1402 70 Country) Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Cecil MD Port Deposit 1 🗆 Yes 2 🖺 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 73 N. Main Street 21904 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Arroed Forces? 1 Yes 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Year or Dates, Korean Era Specify: White 3 Widowed 4 X Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Audrey Smith Quentin W. Blomquist 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Gifford, Daughter 10 Lawrence Avenue, Bayville, NJ 08721 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State science Care Phoenix, Arizona 01;08;2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harman Funeral Service, PA 21. Signature of Fundami Service Licensee 7221 Grayburn Drive, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Necrotizina Theumonia disease or condition resulting in death) Medical Due to (or as a conseque Examiner Ulmanan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examin To the Hospital or Attending Physician; The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical P.O. Box 68760 signed by the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year Yes g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed been si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed' death? certificate 1 X Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 🔀 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Rebecca 29d. Date signed (Month, Day, Year) 24327 102 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 10 31. Date filed (Month, Day, Year)

JAN 0 8 Registrar's Signa State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month AMBER **Physician** 4. 2010 15:36 FM January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Maryland 215-13-3678 25 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location I0d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at MD Carroll Taneytown 1X Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 2 E. Baltimore St., Apt. 21787 IISA should be filed within 72 hours after death v nd Mental Hygiene. • marked other than "natural", or items 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: ō 1 Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specity: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Angelo Bizzarri Patricia Lynn Bizzarri ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessica Fitzgerald-sister 224 Frederick St., Hanover, PA 17331 Health tem 27 Department of Health Important; If Item 27 any injury or other trong once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Pages ' 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State South Carroll Crem 1-6-2010 Winfield, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home 21. Signature) of Funeral Service Licenses homas Z 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CARDIAC disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury burial-transit death certificate be executed that initiated events resulting in death) Last Box 68760. attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 X No
9 ☐ Unknown Month Pregnant at time of death 5 Other (specity) 9 Unknown P.O. the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 XNo 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼ Yes 2 □ No 24a. Was an autopsy performed? hæs 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury completely filled in by the funeral 27 Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 24 hours after death.

Funeral Director: After 5 Pending investigation or Attending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

(check only

Signature and title of certifier

one)

JONATHAN 31. Date filed (Mor

ZELKEN

ss of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

RES-000

29d. Date signed (Month, Day, Year)

January

2010

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Within 2

back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 4:50 PM Linda Blasche January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number Funeral Min. July 8, 1 Maryland 1 🗆 M 2 🔯 Months Days Hours 51 1958 Director 213-72-0990 Usual Residence of Decedent 28a-f shov 10a. State 10c. City. Town or Location death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 No MT Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3120 Wallford Drive #B 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify: If Yes Give Specify: White 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry unk Elementary/Seconday (0-12) 12 College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leo Stephen Bueginerski Josephne Orbino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pat Mugrage/cousin 8 Medici Ct Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 21. Signature of Financi Sen 655 W. Baltimore street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or conditions) Approximate Interval Between Onset and Death Breast Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Month Pregnant at time of death signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 4 Unknown 1 Yes 2 No 3 Probably cate has been signage 2 should b Completed 24b. Were autopsy findings available 24a, Was an autopsy performed Yes 2 prior to completion of cause of death? certificate 2 NO 1 Yes 24 hours after death.

Funeral Director: After this certific leted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Tother (Specify) Hospice မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifie Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one) 29b. Signatute and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

North Charles St Suite

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a Per FH C899 1/08/10/JH State of Maryland / Department of Health and Mental Hygiene 20 10 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:13PM awrence anuar 2010 Medical give street and nun City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Mospita Marbor Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Birthplace Country) MD 1 XXX 2 🗆 Months Hours Min. 04-21-1945 218-42-2802 Director 64 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Halethorpe 1 ☐ Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 4122 Annapolis Road Apt 2B USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black. White, etc "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. Specify: White 1968 Completed 3 Widowed 4 X Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Plumber Construction injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of and 2 should be filed of Health and Mental Histem 27 is marked of Minnie Lee Brown Eulor Mayland Pollard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Old Stage Rd. Apt D, Glen Burnie, MD 21061 April M. Camden / Daughter 20a. Method of Disposition
1 ☐ Burial 2 🖒 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot W. Arundel Crematory 01/08/2010 Odenton, MD 41 Donation 5 Other (Specify) 21. Signature of Funeral Service Dicensee PA

22. Name and Address of Facility
Bailey Funeral Home and Cremation Service, PA

4023 Annapolis Road, Halethorpe, MD 21227 MO1452 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death cancer with liver metastases Physician/ Small cell luna two months Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and trar Due to (or as a consequence of) physician a the burial-Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death g 🗆 Unknown Unknown signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Shock 2 No 3 Probably 4 Unknown has been signed to should to heart failure congestive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate ha 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 유 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation 2 Accident
3 Suicide М within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number RESOUD MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Hanover Street Baltimore Maryland 3001 Brinton State JAN 0 8 2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5:53am M 2010 January 6 HARRIET L. GWYNN COLE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CARROLL CO FINKSBURG 1982 TURNBERRY COURT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** Days Months Hours 1 □ M 20XF Yrs. 55 MARYLAND AUG. 10 1954 Director 220-62-4754 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination and be notified at 1 ☐ Yes 2XXNo Director MARYLAND CARROLL CO FINKSBURG 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21048 U.S.A. 1982 TURNBERRY COURT Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐Yes 2 XNo 1 □ Never Married 2 N Married Maryland 21215-0036 1 ☐Yes 2 X No Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 12 should be filed within 7 in and Mental Hygiene. 7 **is marked other than** "r Elementary/Secondary (0-12) College (1-4or 5+) CAREFIRST I.T. DIRECTOR 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CAROLINE GWYNN REV. MOSES L GWYNN JR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) s 1 and 2 s if Health an item 27 is 1982 Turnberry Ct., Finksburg, Maryland 21048 Ernest Cole/Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 01-14-10 OWINGS MILLS, MARYLAND GARRISON FOREST 4 ☐ Donation 5 ☐ Other (Specify) 2 Signature of Funeral Service License 22. Name and Address of Facility WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, ▶ alm S PHILADELPHIA BLVD., ABERDEEN, MD 21001 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). law requires that the death certificate be executed Exami and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 - Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached f P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tyes cate has been si, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. M. m. r of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation nours after dea h.
neral Director After filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical сотретельно (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number \$ 006 2254 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

LYON WBENKEDERE AVE, BALTIMORE, MD MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician/ 9:30 A. 2010 Janice Colgan Januarv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Villa Assumpta Baltimore If Under 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🕅 F Months Hours (Month Day, Year Mary land 89 Director 213-60-6945 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🗆 Yes 2 🕅 No **Baltimore** Maryland Baltimore 10e, Street and Number 10f. Zlp Code 10g. Citizen of What Country? Funeral 6401 N. Charles Street 21212 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Widowed 4 Divorced White permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education 4 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Colgan Jane Rah11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21212 Sr. Patricia Glinka, S.S.N.D N. Charles Street Baltimore, Maryland 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1-12-10 Glen Arm, Maryland Villa Maria Cemetery 21. Signature of Funeral Service Licensee Name and Address of Facility
tchell-Wiedefeld Funeral Home,
Mary 1 Inc. 6500 York Road Baltimore, 23a. Part 1. Unter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner orana Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) Month Day Pregnant at time of death as been signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed certificate 1 🗆 Yes 2 🗆 No 1 🗌 Yes 2 🗔 25. Was case referred to medica funeral director, Be 26. Place of Death heck only one Hospital Other: 2 No မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? death. 2 No nours after death neral Director: A I filled in by the fi Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [ only on 29b. Signa 7,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) limonum 1407 York

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ARK + PU AND 0 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mandarin Chesapeake Hospice House Harwood Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 M 2 D F Months Hours (Month, Day, Year) 11/15/1959 Washington DC Director 214-84-9517 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at Director MDAnne Arundel Harwood 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3675 Solomons Island Road 20776 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black White etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify. Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Capuano Loretta Parlon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
150/ Tillshire Drive. Crofton, MD 21114 19a. Informant's Name/Relationship (Type, Print) Vincent M. Capuano/Son 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Ardent Cremation Services 01/08/2010 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature Funeral Prvice Licensee 7522 Connelley Drive, Ste.N Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final VER Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) Exami burial-transit and resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Cectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Pregnant at time of death
Unknown signed by the aid be detached for Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an I or Attending Physician: The law safter death. autopsy page 2 death? 1 Yes 2 No Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital 2 🗆 🌃 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA MILLE ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at HOUSE Certificate: 28d. Describe how injury occurred work? injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 0 2010

DHMH 17 Rev 7/2009

State Registrar EFENSE

NNAPOLI)

ompleted cause of death (Item 23a) (Type, Print)

6

amend #5 State of Maryand Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 6, 2010 Year Physician/ HARRIET SMITH DOWNEY 7:05A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heart Homes Lutherville Lutherville Baltimore 5-6-cal Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 X XF Days Hours Aug 1921 <del>215</del>-28-5622 88 Soft Tip Carolina Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10h County 10c. City. Town or Location 10d. Inside City Limits Director Baltimore Maryland Lutherville 1 ☐ Yes**X 2X X** No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1320 Front Avenue 21093 USA 12. Was Decedent Ever in U.S. Armed Forces 1 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or 1 Never Married 2 Married δ 1 ☐ Yes XX No Specify: Completed 3XXWidowed 4 □ Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Interior Designer Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lamar Smith Amaryllis Bomar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Exec/POA 7 St Paul Street Baltimore, Maryland 21202 Frederick Koontz 20a. Method of Disposition
1 □/Burial XXX Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1/7/10 GreenMount Crematory Donation 5 Other (Specify) Baltimore, Maryland 22. Name and Address of Facilitchell-Wiedefeld Funeral Home Signature of Funeral S 6500 York Road Baltimore, Maryland 21212 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one pause on each line. Immediate Cause (Final Onset and Death emplications of disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death

Physician/

Baltimore, Maryland 21215-0036

Box 68760

P.O. |

Records,

**Division of Vital** 

attending physician a for use as the burialhas

by

Completed

To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t

Be Assisted Living 2 X No Hospital: Other: 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier R149194 January 6, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grant

lowson

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

24a Was an

26. Place of Death (Check only one)

autopsy performed?

Yes 2 No

1 Yes 2 No 3 Probably 4 Unknown

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Year

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year) JAN 0 8 2010

23b. Was decedent pregnant

in the past 12 months?

1 Yes 2 No
9 Unknown

25. Was case referred to medical

N. Chales 701 32. Registrar's Signature

Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 I Inknown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year **Physician** ernon Deminas 0 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Balting-e
If Under 1 Year If Under 24 Hrs. NS N/A DUR 8. Date of Birth (Month, Day, Year) 07/15/1947 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours Min **1** M 2 □ F Maryland Director 62 219-50-3037 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director Baltimore N/AMD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò items 23a Fayette Street U.S.A. 1217 W. 21223 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 🔀 No Specify: þ 3 Widowed 4 Divorced Black "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Department of Health and Nental Hygene.
Important: If item 27 is marked other than any injury or other traumatic exceptions. Elementary/Secondary (0-12) College (1-4or 5+) 9th Grade Construction Private Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be DeMinds ပ Alvin Holmes Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7661 Woodpark Lane #204, Columbia, MD 21046 Michele Ford(Niece) 20b. Place of Disposition (Name of Joseph Brown F/And Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/08/10 | Baltimore, MD 22. Name and Address of Facility
Joseph H. Brown Jr. Funeral Home
2140 N. Fulton Ave., Balto., MD 21217 21. Signature of Funeral Service Licensee Wiamo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final acquired immunodeficiency **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-tran Due to (or as a consequence of): physician at the burial law requires that the death certificate attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Ö detached 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas page 2 autopsy performed? Yes 2 No certificate Vital 20KINO 1 TYes 1 □ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of this Certification: To After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending death. 124 hours after death.

le Funeral Director; A
bletely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar avac Cox, h

30. Name and address of person who completed cause of death (III m 23a) (Type, Print)

Bon

Scrous

32. Registrar's

2000 W. Bastimore street Baltimore

Physician

HOSpital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 7:30 AM Marvin January 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner eens 9. Birthplace (State or Foreign Country) If Unde 8. Date of Birth 7. Age (In yrs. last birthday) Funeral 1 M 2 □ F Ce Corrs. 219-40-165 Director "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director andalls 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No Race - American Indian. 11, Marital Status Armed Porces?

1 Yes 2 No
If Yes, Give Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: Blac 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturn important: If item 27 is marked other than "naturn important: Affect than "naturn in the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

i Spatcher (Specify only highest grade completed) /Seconday (0-12) College (1-4 or 5+) grade Be 18. Mot r's Name (First, Middle, Maiden Surname, ٥ Mc Daniels Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 01-15-2016 Owings Hills 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee andalls town, MDZILE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Opset and Death IIIC Stage Cancer 2 year Priysician/ disease or condition resulting in death) 10(01) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence or, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 as the attending IE FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Dav Pregnant at time of death Yes 2 No ed by the a detached f 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? cate has been signed I page 2 should be det. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No within 24 hours a er death.

To the Funeral Director: After this certifical completed filled in by the "uneral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 2. No ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending (Month, Day, Year) injury Natural 5 Pending 1 ☐ Yes 2 ☐ No М 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d, Date signed (Month, Day, Year) 29c. License numbe 6. 2010 eted cause of death (Item 23a) (Type, Print) 30. Name and address of person who come Tree. Rd Sucte 135 Pikesnile, MD 21208 1838 Greene Hrabeth Loeb 31. Date filed (Month, Day, Year) -State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 10:30 A 6. 2010 /Medical January 4c. County of Death acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Towson If Under 1 Year Greater Baltimore Medical Center Baltimore Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 💢 F Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 res 2 No Director Street and Number 10g. Citizen of What Country? 'natural", or items 23a or by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Statu 14. Bace - American Indian. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify: 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Is marked other 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle Be Pages 1 and 2 should be Holmes 19b. Mailing Address (Street and Number or Rural Route Number, City (Change Street and Number or Rural Route Number, City (Change Street) 19a. Informant's Name/Relationship Important: If item 27 Is any Injury or other trainonce. chelle Baltimore. Method of Disposition ŏ Burial 2 Cremation 3 Removal from State Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MO 155 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dumoniery 4440 a Doueve /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to minimize a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes funeral director, page 2 should Be Completed distretion 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe Hospital or Attending Physician; The this certificate i. Was case referred to medical examiner? 2 No 1 □Yes 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To N☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA . Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident within 24 hours after deatl To the Funeral Director: filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02090 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

**Physician** /Medical Examiner Eyre Velme Incz. Mocoogg 352 Division of Vital Records, P.O. Box 68760,

been signed by the attending physician and should be detached for use as the burial-tran After this certificate has I funeral director, page 2 s To the Hospital or Attending Physician: within 24 hours are reath.

To the Funeral Director: After this certified completely filled by the funeral director, for the funeral director di

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

23a or 2

Department of H Important: If Iten any Injury or oth once.

Director

Completed by

Be

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Physician/Medical Examiner

Medical Certification: To Be Completed by

NASRIN

31. Date filed (Month, Da

the Maryland

Saltimore, Maryland 21215-0036

shock, or heart failure. List only o	one cause on each line.				Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. possible sept	ic Shock			Oliset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injlury that initiated events resulting in death) Last	etion	ì			
	3	0			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		opic pregnancy er (specify)		23d. Date of deliv Month	rery Day Year
Part II Other significant conditions of	ontributing to death but not resulting in the underly	ing cause given in Part I	23e Did tobacc	o use contribute to t	the cause of death?
Acute ren			5		bably 4 Unknown
depression	ese, DM, Smei	e Demetra	24a. Was an autopsy performed 1 □ Yes 2	prior to co death?	opsy findings available ompletion of cause of
25. Was case referred to medical		26. Place of Dea	th (Check only one)	•	
examiner? 1 ☐ Yes 2 🔯 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3	□ DOA Other: 4 □ Nursing H	ome 5 Residence	6 ☐Other (Speci	(ty)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street City or Town, St	and Number or Run ate)	al Route Number,
29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysiclan: To the best of my knowledge, death occuniner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place ation, in my opinion, death occu	, and due to the cause rred at the time, date a	e(s) and manner as and place, and due to	stated. o the cause(s)
29b. Signature and title of certifier		29c. License number	29d. I	Date signed (Month,	Day, Year)
1 April	MD	D0068014	J	anuary	(e. 2010)

State

500 UPPER CHESAPEAKEDR BELAIR MD-21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** anuari 2016 /Medical County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Baltimore General LOSPITAL maryland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 □ F -30-9110 Carolina Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show Department of Health and Mental Hygiene. Important: if item 23a or 28a-f shov important: if item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examinar must be notified at 1 Nes 2 No Director Maryland 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Pres 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: Blac 1□Yes 2┗No If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machine Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Pages 1 and 2 should be 1 Edmond Ellerbe Isabel ပ 19b. Mailing Address (Street and Number or Rural Beyte Number, City or Town, State, Zip Code)
3803 Seguoia Ave. Battimore, Marylan 19a. Informant's Name/Relationship (Type. Print) Malik Salaam-son 20b. Place of Disposition (Name of cemetery, crematory or other re Baltimore, 20a. Method of Disposition or other place, 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) neumonia ateral **Physician** /Medical Due to (or as a consequence of): Examiner 315 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last for as a consuduence off Examiner mentia the burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) P.O. 9 Unknown detached signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by 3 Probably 1 ☐ Yes 2 ☐ No page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Attending Physician: The 1 ☐ Yes 2 ☐ No 1 □ Yes 2 No Division of Vital After this certification funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2☑No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: Air completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ŏ 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier somastiercas. 30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) Daryland General lom astrewas 32. Registra s Signature 31. Date filed (Month, Day, Year) State Registrar

10-00013 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Chad Christopher Eggers State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 1, 2010 Chad Christopher Eggers 1400 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cumberland Allegany 505 East Second Street 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreian Days Director 216-23-1692 20 Jan. 3 1989 1X M 2 F Country) MD Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Allegany Cumberland 1 X Yes 2 No 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 505 Second Street 듑 21502 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Yes 1 Yes 2 No specify: White 3 Widowed f Yes, Give Year 4 Divorced Specify: ੬ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than Baltimore, MD 21215-0036 10 Laborer Labor of Health and Mental Hygiene If item 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Raymond Eggers Pamela Sue Beitzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie D. Beitzel, Sister 459 Bill Beitzel Road, Grantsville, MD 21536 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 01/06/2010 Glen Burnie, MD 4 Donation 5 Other Specify: 22. Name and Address of Facility Newman Funeral Homes, PA 21. Signature of uneral Service Licensee Harman 179 Miller St., P.O. Box 275, Grantsville, MD the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and (Modical Death Carbon monoxide intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last sician/Medical X UNPENDED AMENDED 23a,27,28a-f,perME g899 1/13/10 TT The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth Fetal death 2 Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o ğ ۵. 1 Yes 2 No 3 Probably 4 V Unknown Completed Records. 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? performed certificate Yes 2 No 1 🗸 Yes Hospital or Attending Physician; 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA this 1 V Yes 28c. Injury at Work? 28d Describe how injury occurred After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of Injury Certification: Natural inhalation of combustion 5 Pending 1 Yes 2 X No within 24 hours after death. To the Funeral Director: Director: d in by the f fumes /1/2010 :45 pm 2 X Accident 28f Location (Street and Number or Rural Route Number, City or Town, State) 505~E.~2nd~St.umberland, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be (Specify) shed Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifig 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

Jack Titus MD. Deputy Chief Medical Examiner

Date filed (Month, Day, Year) 32. 8 gistrar's Signature

31. Date filed (Month, Day, Year) 32. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a)

ledical Examiner 111 Penn Street, Baltimore, MD 21201

O.C.M.E

January 2, 2010

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Egistrar's Signatur

		amend #20b Per FH G899 1/12  For State of Maryland / I  State Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No. 2	3. Time of Death
Physici Medi Exami	cal	4a. Facility Name (if not institution, give street and number)	4b. City, Town or Location of Death	Month Day ,	10 2:05 pm
Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birt)	Towson	. Date of Birth	TIMORE
Director		580-02-5069 1 M 2 □ F 58 Usual Residence of Decedent	Yrs. Months Days Hours Min.	(Month, Day Year)	9. Birthplace (State or Foreign Country)
Maryland 28a-f sho	irector		Himore		10d. Inside City Limits 1  Yes 2 □ No
th with the ms 23a or must be r	Funeral Director	3106 Luch Raven Blvd	10f. Zip Code 2/2/18		/hat Country?
rs after dea rral", or iter Examiner	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric     □ Yes 2 No Specify:		- American Indian, k, White, etc. Black
Z I Z I D-UUJO within 72 hours after giene. er than "natural", o the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Bu	siness Industry
IOFC, INICIVIATION ZIZID-UU30 ge 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To Be C	17. Father's Name (First, Middle, Last)  OSlph Friderick	18. Mother's Name (F	irst, Middle, Maiden Surname)	16
t, INGLY		Lloyd Hederick Brother 17	. Mailing Address (Street and Number or Journal R 54 Wentworth Aver	oute Number City or Town, St.	ate, Zip Code) re. Mary luny 21.
T Pa			i Disposition (Name of y, crematory or other, place) LIE Camathin (tv. 1110)	1010 Balfil	City or Town, State  1072, Marylan
permit. Departin Imports any inju		21. Signature of Funeral Service Ucensee  M 9/553	23. Name and Address of Facility Vaughn C. Greene F.	2. 14405. 40. 2. 1841 times	rk Kraj re, Ma. 21212
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of the condition of the cond	Cancer	espiratory arrest,	Approximate Interval Between Onset and Death IM IM
	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury that initiated events  C	of):		
ate be executed hysician and the burial-transit	g	resulting in death) Last  Due to (or as a consequence of d	vf):		
DIVISION OF VITAL INSCRIPTORY, F.O. BOX 90 OCT TO the Hospital or Attending Physician: The law requires that the death certificate is within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date Mon	e of delivery th Day Year
do, r.O. quires that then signed by vuid be detact	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacco use contrit	pute to the cause of death?  3 Probably 4 Unknown
of Vital necolus, g Physician: The law requires ter this certificate has been signeral director, page 2 should	Completed	25. Was case referred to medical		autopsy pr performed? de 1  Yes 2 Wo 1	ere autopsy findings available rior to completion of cause of eath? Yes 2 \( \sum \) No
Physiciar This certiiral directo	: To Be	25. Was case referred to medical examiner?  1  Yes 2 M No Hospital: 1  Inpatient 2  ER/Out  27. Manner of Death 28a. Date of injury 28b. T		5 ☐ Residence 6 ☐ Other	
CINISION OF THE CONTROL OF THE CONTR	Certificate:		njury work?  M 1 □ Yes 2 □ No	I. Describe how injury occurred  Location (Street and Number City or Town, State)	
Hospital o 24 hours af Funeral Di sted filled in	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, conduction (Check 2 Medical Examiner: On the basis of examination and/or	r investigation, in my opinion, death occurred at the	ue to the cause(s) and manner	to the cause(s) and manner state
To the within 2 To the comple	Σ	only one) 3 Certifying Nurse Practioner: To the best of my knowled 29b. Signature and title of certifier	edge, death occurred at the time, date and place, a 29c. License number	and due to the cause(s) and man 29d. Date signed	
		30. Name and address of person who completed cause of death (Item 23a) (There is the complete of the complete	Type, Print)  (1) N (LARLIS CT	- POWSON /	NO
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 1 0 3	, — —	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JAN 2010 **Physician** 1:55P M DORIS P. FOSLER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Oak Crest Renaisance Care Center Baltimore County If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Social Security Number **Funeral** Year Days Hours 92 212-12-4779 Director June 8. Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it e Modical Examinating must be notified at Baltimore County 1 ☐ Yes XXNo Maryland Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 USA 8800 Walther Blvd. Apt. 1402 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married XX Married ファックロリン ア3トドバー Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore City College (1-4or 5+) 6 yrs. Elementary/Secondary (0-12) Public Schools Teacher 12 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred L. Shriner Roland A. Patton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard B. Fosler, Jr. (Husband) 8800 Walther Blvd. Apt. 1402 Balto., Md. 21234 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State Metro Crematory, Incil-11-2010 Baltimore, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee ្បីassamh<sup>Ad</sup>ក្សាក់ទីក្លាប់ Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner DEMENTIA Due to (or as a consequence of) かんな ド・バントレントレンン Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) 1 □ Yes 2 No 9 □ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Dea 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day, Year) Division Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital or Certifying Physician: To the lest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Des CRI address of person who completed cause of death (Item 23a) (Type, Print) 8800

Registrar

State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00200 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 7:00 A M 2010 JANUARY 4, ESTHER SELFE FINE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SMITH'S CARE FOR THE ELDERLY **EDGEWOOD** HARFORD If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔽 F **Director** 107 Mar. 30, 1902 Virginia 224-26**-**3281 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show Item 27 Is marked other than "natural", or Items 23a or 28a-f sho other traumatic event, the "had all Examinat is ust by notified all 1 ☐ Yes 2X No Director Maryland Harford
10e. Street and Number Abingdon 10g. Citizen of What Country? 20 Boxhill South Parkway Apt. Funeral <u> 21009</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo þ Specify Specify: White **3** Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home t of Health and Mental Hy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ross (nmn) Selfe Sally Ann Stone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Inez E. DeFazio / Daughter 20 Boxhill South Parkway, Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-9-2010 Temple Hill Mem. Pk Castlewood, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility.

McComas Funeral Home, P.A. athlee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Immediate Cause (Final CARNOVASCULAR IN SKE DURSYES **Physician** resulting in death) /Medical Due to (or as a consequence of): ONER SYRE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed Exami and burial-tra Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending portion IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Ö 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, CANC 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? · has h 24a. Was an perform this certificate 1 ☐ Yes 2 🗹 No 1 ☐ Yes 2 ☐ No of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ASSISTED LIVILE Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1∐ Yes 2 No ithin 24 hours after deau...

o the Funeral Director: After this in the funeral director is a fine funeral director. 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within To the DØØ16389 JANVIRY 4, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1716 HARPORD ROLD SMITE 108 FAUSTON MID VALARAO M.O. ERFECTO C

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0 8 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29a, per DVR g899 178/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 01-06-2010 Year **Physician** Margaret F. Gervais 1245 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Timonium Baltimore Stella Maris Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 04-21-1921 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🕏 F 88 MD 212-18-2379 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☑ No Director MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 2300 Dulaney Valley Rd #183 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Inspector Lithograph Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, II once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cicero Scott Marie Kram 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Gervais, Jr 14 Waterview Rd Baltimore, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donapion 5 ☐ Other (Specify) 01-08-2010 Parkwood Cemetery Baltimore, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mor disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be execut the burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown ed by t detach s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has b page 2 sh autopsy performe certificate 2 No 1 □ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation 1 🗆 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JANUARY 6, 2010 \$157620 30. Name and/address of person who completed cause of death (Item 23a) (Type, Print) JENNIFER HAUF, C.R.N.P 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 31. Date filed (Month, Day State Registrar

JANUARY

GERVAIS

NARGARET

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GRUBB **Physician** CONENCE M. 010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FRANKLIN SQUARE HOSPITAL CENTER Baltimore Roseda Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🛣 F Days Hours Min. Director 03/16/±934 215-30-4774 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Exercities inter the profiled at 1 ☐ Yes 2 No Director Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4312-1/2 Silver Spring Road 21128 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ∐Yes 2X No ð If Yes, Give Year or Dates: Specify. Specify: 3 Widowed 4 Divorced White Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 **Homemaking** Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dominic Stella Elizabeth Firstein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Grubb (husband) 4312-1/2 Silver Spring Road - Perry Hall, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 101/08/2010 Sykesville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. Hhor 11750 Belair Road - Kingsville, Maryland 23a, Part 1, Enter the diseas Part 1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical POWEL OBSTRUCTION

RENAL FAILURE

PENSE OFF VENONALE Examiner Se wentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed burial-tran Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes 2□No 9 Unknown signed by t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' certificate 2 □ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After th funeral 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 🗷 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

P.0. Division of Vital Records, Hospital or Attending Physician: within 24 hours after death

To the Funeral Director: ,
completely filled in by the f

> State Registrar

Medical

29a. Certifier

JAN 0 8 2010

2. Registrar's Sign

and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Batte, Mel 21237

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day JANUARY 5, 2010 23:53 BONNIE JO GOODMAN 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death UPPER CHESAPEAKE MEDICAL CENTER HARFORD BEL AIR Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Months Hours 1 □ M 2 🔀 F 2, 1946 MARYLAND 218-42-4886 63 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No HARFORD BEL AIR MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2508 GLADSTONE CT. USA 21015 . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 📉 No Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) VICE PRESIDENT BANKING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GUY RICHARD MARTIN VIRGINIA GERALDINE DERTINGER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JOHN E. GOODMAN / HUSBAND 2508 GLADSTONE CT., BEL ATR, MARYLAND 21015 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State TOWSON, MARYLAND HILLTOP SERVICE CORP: 1-8-2010 4 ☐ Donation 5 ☐ Other (Specify) MCCOMAS FUNERAL HOME, P.A. 1317 COKESBURY ROAD, ABINGDON, MARYLAND 21009 21. Signature of Funeral Service Licenses 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) I ☐ Yes 2 🗹 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

**Physician** /Medical **Examiner** 

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

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Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

t. Pages 1 and 2 should be filed within 72 hours after timent of Health and Mental Hygiene.

is marked other

injury or other traumatic event,

Important: If item 27 is any injury or other trau

Maryland 21215-0036

Examine

Physician/Medical

\$

Completed

Be

Certification: To

Medical

1 ☐ Yes 2 🖾 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a Certifier

4 Homicide

(Check only one)

attending physician

death certificate be executed o requires that the of Vital Physician:

Records,

Division Hospital or Attending after death Director: To the Hospital or within 24 hours a To the Funeral D

onna

State Registrar

31. Date filed (Month, Day, Year)

5 Pending investigation

6 ☐ Could not be

29b. Signature and title of certifier

D0056607 January 6th,

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day, Year)

and manner stated.

JOSEPH ANGELO # 205 602

S. ATWOOD Rd, BELASK, MD 21016

32. Registrar's Signatur

1 Dopatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, Month Day Year M **Physician** 2010 /Medical 4c. County of Death 4b. City. Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** Maryland Medical Center Baltimor If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
India 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ፟ M 2 ☐ F Hours Min. Months Days June 16, 1945 217-90-5530 64 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiens, 77 is marked other than "natural", or items 23a or 28a-f show 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, Ite Marked Examiner must be profitted at traumatic event, 1 ☐ Yes 2X No Director Maryland | Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 United States 12414 Buckley Drive Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: Asian-Indian þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Architect 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Prem Kapur Chunilal Gulati 1 and 2 should to Health and Ment tem 27 is marked ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12414 Buckley Drive, Silver Spring, Maryland 20904 Anjali Gulati/Wife permit. Pages 1 and:
Department of Health
Important: If item 27
any injury or other tr 20b. Place of Disposition (Name of Mont gome 1 y Date 20c. Location - City or Town, State 20a. Method of Disposition January 10, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bethesda, Maryland Crematorium, Inc. 4 Donation 5 Dother (Specify) 2010 bethesda-Chevy 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, 21. Signature of Juneral Servin Licensee | Kopert A. Fumphrey Funeral Home/ Chase, Inc. | 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final one day Physician neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed Due to (or as a consequence of) physician ar s the burial-t Box 68760, Physician/Medical attending pl If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No P.0. the detached 9 Unknown 9 Unknown signed by 1 d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? renal 24a. Was an autopsy perform 2 🗆 No certificate 2 1 ☐ Yes 1 ☐ Yes upus 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death (Month, Day, Year) Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital or Attending P 24 hours after death. Funeral Director: After t within 2.

> State Registrar

Medical

31. Date filed (Month, Day, Year) JAN 0 8 2010

29b. Signature and title of certifier

indatabai

29a. Certifier

32. Registrar's Signatu

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State		State of N	1aryland		rtment ( ificate (			d Mental Hy		0010	00205
			Hegistrar     Decedent's Name (First, Middle, Last)					mouto	0, 00		2. Date of De		han 🔾 1 🔾	3. Time of Death
	Physicia Medic	al	Christo			ardes					Jan	5		8:20a <sub>M</sub>
	Examiner  4a. Facility Name (if not institution, gastella Ma				eet and number) e Hosp	ice		4b. City, Tov	wn, or Lo		eath	40	County of Death. Baltim	
	Funeral Director		5. Social Security Number 218-26-23	6. Sex	M 2 □ F 7. A	ge ( <i>In yr</i> s. <i>I</i> as	t birthday) Yrs.	If Under 1 Months		f Under 24 Hours N	Hrs. 8. Date of Bi	th Year)	9. Birti Cou	nplace (State or Foreign ntry) MD
	d t ow		Usual Residence of Deced	ent County		10c. City	Town or Loca	ation						10d. Inside City Limits
	larylan 8a-f sh iified a	Director	MD	Balti	more	, , ,		sex						1 ☐ Yes 2 ☒️No
	with the M s 23a or 28 ust be not	Funeral Dir	10e. Street and Number 957 Hombo	erg Av	enue				2122	_		Ů	ltizen of What Col USA	
8:20 a.m. 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2. 3 ☐ Widowed 4 ☐ D	K Married	2. Was Deceden Armed Forces 1 XYes 2 If Yes, Give Year or Dates.	?	1	☐ Yes 2	No No	Specify:	? (Specify Yes or No uerto Rican, etc.)			hite
20 15-0	72 hou n ''natu ledica	Completed	(Specify on	Decedent's Educ ly highest grade	completed)			ent's Usual C ind of work of NOT use re	done dur	on ing most of	working		Kind of Business I	ndustry
8:20 21215-	ed within Hygiene. o <b>ther tha</b> ent, the N		Elementary/Seconday	(0-12)	College (1-4 o	r 5+)	Litho		,			Lit	thograp	her Co.
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5, 2010 Maryland	should by and Mer is mark raumatic		William 19a. Informant's Name/Re				19b. Mailine	Address (S	Street and	d Number o	r Rural Route Numb	er, City c	r Town, State, Zip	Code)
	and 2 sh Health ar tem 27 is		Joan Har	dester	/wife		957	Homl	ber	g Ave	nue Bal	timo	ore MD	21221
JANUARY Baltimore,	Page 1 ar nent of He ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cre 4 ☐ Donation 5 ☐	mation 3 🗆 R	emoval from Sta	te Ba	ace of Dispos metery, crem YV1eW	atory or other Crei	of er place) matc	ory 1	/ 8/10		ocation - City or	
JAN	permit. I Departn Importa any inju		21. Signatus Fyreral S	6 R	Per	us	9949	Conn	elly	y Fun	300 Mac eral Ho	me_c		
			23a. Part 1. Enter the disc shock, or heart failur	ease, or complice. List only one	cations that caus cause on each i	ed the death. ine.	. Do not ente	r the mode o	of dying,	such as car	diac or respiratory a	irrest,		Approximate Interval Between Onset and Death
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a a	CHRONI	C OBST		E PUL	MONA	RY DI	SEASE			
1	Examiner		Commentative line and distance		Duc to (01 2	o a conceque								
	d sit	Examiner	Sequentially list condition if any, leading to in a cla cause. Enter Underlying	ite 2	Due to jor a	is a conse jue	ence off:							
	xecute n and al-trans	Exar	Cause (Disease or linjury that initiated events resulting in death) Last	c	Due to (or a	s a conseque	ence of):							
و م	ate be executed physician and the burial-transit	dical			l									
HARDESTER O. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death within 24 hours after death to the Funeral birector: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregn in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	anı	3c. If yes, outcon 1  Live Birt 4  Pregnan 9  Unknow	h 2 ☐ Fetal t at time of de	death 3 🗀	Ectopic pre Other (spec					23d. Date of de Month	ivery Day Year
~ □	quires that the	ted by Ph	Part II. Other significant	conditions con	tributing to deat	h but not resu	ulting in the u	nderlying ca	use give	n in Part I.	1	Yes :	2 □ No 3 □ P	the cause of death?
CHRISTOPHER Division of Vital Records. F	The law recate has be page 2 shi	Completed									per 1 🗆 Yes	s an opsy formed? s 2 1	prior to death?	topsy findings available completion of cause of
CHR	rsician s certifi	To Be	25. Was case referred to r examiner? 1 ☐ Yes 2 🗶 No	_	ospital:	atient 2 🗆 I	ER/Outpatien	t 3 🗆 DOA	Other		(Check only one) ina Home 5 □ Re	sidence	6X Other (Spec	ify) HOSPICE
n of \	iding Phy th. After this funeral c	cate: T	27. Manner of Death 1	Pending Investigation	28a. Date of i		28b. Time of injury		c. Injury a work?	at	28d. Describe			
Divisio	I or Atter after dea Director	Certificate:		Could not be determined	28e. Place of building,	Injury - At hor etc. (Specify)	me, farm, stre	eet, factory,	office		28f. Location City or To			ral Route Number,
	ne Hospitz n 24 hours ne Funeral pleted fille	Medical	(Chack 2 M	edical Examin	er: On the basis of	of examination	and/or invest	igation, in m	v opinion	. death occu	ace, and due to the urred at the time, date and place, and due to	and place	ce, and due to the	cause(s) and manner stated.
4	To the within		29b. Signature and title o	certifier	CANT	0		29c. [	License i	number 192		29d. D	Pate signed (Mont	h, Day, Year)
	6V		30. Name and address of		mpleted cause o							1100		
	Sta Registr		JACKIE JO 31. Date filed (Month, Da)		32	DULAN strar's Signat		LLEY R	(I) <u> </u>	TIMON	NIUM, MD	Z1U9)	1	

DHMH 17 Rev 7/2009

8:20 a.m.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 8.2010 **HOOVER** JOHN DAVID 2:12A Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral **XX**M 2 □ F Days Months Hours Min. Jan 26, 1940 69 MarÿTand **Director** 216-38-4121 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2√1X No Baltimore Lutherville Marvland 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o with 1 Funeral 8513 Valleyfield Road 21093 USA hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes XX No 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates Specify: 3 Widowed W Divorced Completed White er than "natura", the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Construction is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert Walter Hoover Medora Laura Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau DTR 66 Montview Court Cockeysville Maryland 21030 Laura J Hand 20b. Place of Disposition (Name of cemetery, crematory or other place) Date GreenMount Crematory Jan 9,2010 Baltimore, Maryland 4 Donation 5 Other (Specify) nature of Funeral S 22. Name and Address of FaMivtchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician/ omo lications disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): death certificate be executed the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph for use as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 2 🗌 No ed by the a detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician; The law requires 2 ☐ No 3 ☐ Probably 4 🛱 Unknown 1 Tes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 X No 1 Yes 2 No To the Hospital or Attending Physician; I within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director, I 25. Was case referred to medica 26. Place of Death (Check only one) æ examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🛱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, 6701 N. Charles St

32. Registrar's Signature

Marian Grant

31. Date filed (Month, Day, Year)

R149194

MD

Towson

January

8

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #2, per DVR g899 1/8/10 TT State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death Day 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month awuns = 21 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death bultimore vice altmore If Under 24 Hrs. Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 □ M 2 Days Months Min. **Director** hareh Usual Residence of Decedent or 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at 10c. City, Town 9r Location 10d. Inside City Limits Director mare 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral items 23a 2 000 2 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō Never Married 2 Married þ 21215-0036 1 Yes 2 No Specify "natural", 3 Widowed 4 Divorced Specify Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) ome Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) clau Hawkins injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory 21. Sign: re of Funeral Service Licens Name and Address of Facility any 229 eca disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. 23a. Part 1. Enter the dis shock, or hear failu Immediate Cause Final disease or condit on Approximate Interval Between Physician/ anoma OVCC ears Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physiciar Physician/Medical P.O. Box 68760 as the IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? þ Month Pregnant at time of death the funeral director, page 2 should be detached 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Mellitus 1 Yes 2 No 3 Probably 4 Noknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 DANO ဥ 1 🗌 Yes two 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Sther (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Description in Visit bearing in Visit bearing with very sear of the causes of any investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 68286 January 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) West . Charles St, Bultimore, MP E 701 MY 31. Date filed (Month, Day, Year) 32. Registra State Registrar **2010** ≥

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 Year Physician/ January 6, 11:59 A M Eugene Howard, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Baltimore Rosedale If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Months Days Hours 1171971936 Pennsylvania 73 Director 160-30-7592 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County within 72 hours after death with the Maryland Director 1 Yes 2 XXNo Maryland Cecil Conowingo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21918 U.S.A. Parkway, Box 453 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No <u>6</u> Maryland 21215-0036 1 ☐ Yes 2X No If Yes Give Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Heavy Equipment Mechanic Balto. County Gov't. Be 18. Mother's Name (First, Middle, Maiden Surname) It. Page 1 and 2 should be a strength of Health and Mental Hy artment of Health and Mental Hy artment of the marked of the marke 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once. Julia unk, Ralph Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Priscilla Starck (Daughter) 168 Riverside Road, Baltimore, Maryland 21221 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Gardens of Faith 01/09/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bruzdziński Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Signature of Funeral Service shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ Medical disease or calditi resulting in eath) dition Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Day Month Year Pregnant at time of death signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by umonar 2 No 3 Probably 4 Unknown should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy perform certificate 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Yes →npatient 2 ☐ ER/Outpatient 3 ☐ DOA 잍 this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury work? 1 ☐ Yes 2 ☐ No 1 Natural Accident
Suicide Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of 29d. Date signed (Month, Day, Year) January 7, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

クV

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) 32 Registrar's Signatur

Savitha Shivananda, 1124 Mace Avenue, Baltimore, Maryland 21221

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registra

Mohan Rudrappa.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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	uneral irector	
h the Maryland	or 28a-f show	irector

Pages 1 and 2 should be filed within 72 hours after death wit nent of Health and Mental Hygiene. ant: If item Z7 is marked other than "natural", or items 23a c ury or other traumatic event, it "Medical Eracinar muth. Baltimore, Maryland 21215-0036 permit. Page Department of Important: If any Injury or once. **Physician** /Medical Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-tra Box 68760. P.O. Records. of Vital this funeral **Division** after death within 24 hours a

To the Funeral I

completely filled State Registrar

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2010 Ann R. Hacia 9:25 AM January 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 22, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Hours Days 1 □ M 2 □ F 55 Yrs 1954 224-86-4068 Germany Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Churchton Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5609 Gunner Run Road by Funeral 20733 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Office Manager</u> Landscaping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ္ဝ Unk. Ruth Smedley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Hacia, Husband 5609 Gunner Run Road Churchton, Maryland 20733 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 01/07/10 4 □ Donation 15 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service License Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 roman Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final Pulmonary Embolisin disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if an leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 X No 1 🗷 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 💆 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed, (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1)46052 1/5/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) [ahway 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 0 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BERNARD HOEFLI 56 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Of Severna Park Severna Park Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Dec 14, 1917 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months Days Hours Maryland 215-05-4392 92 Yrs. Director Usual Residence of Decedent led within 72 hours after death with the Maryland Hygiene.
Hygiene, other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Severna Park 10e. Street and Number 109. Citizen of What Country? Funeral 43 West Mckinsey Road Apt.123 21146 **USA** 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? 1939 Black, White, etc. 1 Never Married 2 X Married 1 V Yes 2 No ò Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: 1945 Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2 should be filed with h and Mental Hygien 7 is marked other th Immigration/Naturalization Officer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gilson W. Hoeflich Florence Doroff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is Margaret R. Hoeflich, Wife 43 West McKinsey Road Apt. 123 Severna Park, MD 21146 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. 01/07/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society Of Maryland, Inc 299 Frederick Road Baltimore, Maryland Thomas Gregor 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed hours after death. Cause (Disease or linjury nding physician and use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for us 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2: autopsy performe death? certificate 2 No 2 X N 1 Tyes 25. Was case referred to medical a 26. Place of Death (Check only one) Hospital 1 Tyes 2 XNO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural Certificate: 28d. Describe how injury occurred 5 Pending 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💯 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signaty 29d, Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>D</sup>3, 2010 January 2:40 PM Hobart Mary Julia 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | North | Nor 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1□M 2₩ F 72 Massachusetts 029-28-3620 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Siloam Springs Arkansas Benton 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number United States 72761 23803 Sycamore Heights Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 □Yes 2 X No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruby Smith Albert M. Maslen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23803 Sycamore Heights Road, Siloam Springs, AR 72761 Chester E. Hobart / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition January 5, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc Bethesda, Maryland 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M01305 Robert A. Pumphrey Funeral Home/Bet 7557 Wisconsin Avenue, Bethesda, Man 23a. Part I/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. R22. Name and Address of Facility Uneral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Approximate Interval Between 48 Hours Immediate Cause (Final Acute Myocardial Infarction disease or condition resulting in death) Due to (or es e consequence of): Years Coronary Atherosclerosis Sequentially list conditions, if any, leading to many diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12\_months? 1 ☐ Yes 2 🖾 No Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 1 🔼 Natural 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Examiner / the attending physician and shed for use as the burial-trar 14to 22 68760 The law requires that the death certificate be Box cate has been signed by the page 2 should be detached o σ. Records, of Vital BART, MARY Division or Attending death. Director.

**Physician** 

**Examiner** 

**Funeral** 

**Director** 

l be filed within 72 hours after death with the Maryland ntal Hygiene.

Baltimore, Maryland 21215-0036

d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be redified at

h and Mental Hygier 7 Is marked other th

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n any Injury or other traun once.

Physician

/Medical

/Medical

Director

Funeral

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Be Completed

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þ Completed Be Certification: To

Medical

3 
Suicide

29a. Certifier

4 Homicide

(Check only one)

Physician/Medical

Examiner

State Registrar 29b. Signature and title of certifier ance

1241507

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3301 New Mexico Avenue, NW, Washington, D.C. 20016 Nancy J. Davenport, M.D.

31. Date filed (Month, Day, Year) JAN 0 8 2010

6 Could not be determined

32. Registrar's Signature

and manner stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death plent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner Town, or Location of Death 4c. County of Death 8. Date of Birth g. Birthplace (State or Foreign (In vrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Months Hours Min Director or 28a-f show 10a. State 10b. County 10c. City, Town or Location he Medical Examiner must be notified at 10d, Inside City Limits Director 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a death \ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes No 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hyglene. Important: If item 27 is man ed other than College (1-4 or 5+) Be 17\_Father 18. Mother injury or other traumation 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1,339 Page 1 and 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H 1 ☐ Burial 2 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Gen vice I censee any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dvid uch as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician disease or condition resulting in death) omolic ations Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): physician Physician/Medical Box 68760 the use as 1 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ sate has been signed by the atterpage 2 should be detached for it in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 No Yes 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury work?
1 ☐ Yes 2 ☐ No 5 Pending Accident Suicid Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Decrifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R149194 January 5,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 105 10WSON

OHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			Please			delible Ink. Ensure	_	•
		-	For State Registrar	State of Ma		artment of Health and rtificate of Death		ene 1. No. 2010 00214
	nysicia Medic	ın	1. Decedent's Name (First, Middle, L William Perry	Jackson	$\cap$		2. Date of Death Month Januar	Day Year II:46P M
E	kamin	er	4a. Facility Name (If not institution, g Northwest Hospit			4b. City, Town, or Location of Dea		4c. County of Death  Baltimore
	neral ector		5. Social Security Number 213-78-5548	Sex 1 M 2 □ F	e (In yrs. last birthday) 49 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min	9. Birthplace (State or Foreign Country)	
tryland	1st	j	Usual Residence of Decedent  10a. State  10b. County		10c. City, Town or Lo	le	<del>-</del>	10d. Inside City Limits 1 ☐ Yes 2 ★No
the Ma	rottlin	Director	10e. Street and Number	more	GWYN	10f. Zip Code	100	g. Citizen of What Country?
eath with	nunt De	eral D		lar Court		2(207	Specify Voc or No	USA  14. Race - American Indian,
5-0036 72 hours after death with the Maryland natural" or items 23a or 28a-f show	Examinst must be notified at	by Fu	11. Marital Status  1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1	everin U.S. 13.	Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Puei 1 □Yes 2 No Specify:	specify res or No- rto Rican, etc.)	Black, White, etc.  Specify: Black
15-00% n 72 hours	adical	Completed	15. Decedent's (Specify only highest of	rade completed)	(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	orking 16	Sb. Kind of Business/Industry
d 2121 filed within Hygiene.	event, tre		Elementary/Secondary (0-12) (2+h grade)	College (1-4or 5		ruck Driver		Transportation
Iryland 2 should be filed and Mental Hygi	ic even	To Be	17. Father's Name (First, Middle, La.  Robert Lee	Tackson		18. Mother's Na Glady	ume (First, Middle, Ma	iden Surname)
Maryland 21215-0036 and 2 should be filed within 72 hours attails and whenlet Hygien 27 is marked other than "natural" or 71 is marked other than "natural" or	2 E		19a. Informant's Name/Relationship  Jenifer Jack	(Type. Print)		ng Address (Street and Number or F	Rural Route Number, (	City or Town, State, Zip Code)  nn Oak MD 21207
Ore, esta of He			20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Special Control of Control	☐Removal from State	20b. Place of Dispo	sition (Name of natory or other place)	Date 20	Saltimore MD
Baltimo permit. Page Department of	any Injury once.		21. Signature of Funeral Service Lic		<del></del>		aug	lalistown MD 21133
			23a. Part 1. Enter the disease, or co shock, or hearth lure. List on	mplications that caused ly one cause on each lin	the death. Do not en			
Physi /Med	_		Immediate Cause (Final disease or condition resulting in death)		osclonatic a consequence of):	Condiovascula	y Discos	e
Exam	iner	<u>.</u>	Sequentially list conditions,	b				
cuted	ransit	Examiner	Sequentially list conditions, if any, leading to infine duals cause. Enter Underlying Cause (Disease or injury that initiated events	C.	a consequence of):			
8760, icate be execut	e burial-transit	=	resulting in death) Last	Due to (or as	a consequence of):			
Box 687( eath certificate   attending physi	for use as the bu	n/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome				23d. Date of delivery
ords, P.O. Box 687 requires that the death certificate been stoned by the attending phys	be detached for	Physician/Medica	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown		☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
rds, Fuires that	ld be del	کر ا	Part II. Other significant conditions	. 11	ut not resulting in the u	nderlying cause given in Part I.		cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown
lecorol law requires been	e 2 should	Completed		1			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
tal Roan: The Ifficate h	irector, page 2 s		25. Was case referred to medical			26 Place of De	performe 1 □ Yes 2 eath (Check only one)	XINO 1 □ Yes 2 🔯 No
of Vita Physician:	funeral director,	To Be	examiner? 1XYes 2 □ No	Hospital: 1 ☐ Inpatie		nt 3 DOA Other: 4 Nursing	Home 5 ☐ Residen	ce 6 ☐ Other (Specify)
/ision of Attending Physic releath.	e funera	ation:	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Inju (Month, Da ion	ry 28b. Time o y, Year) Injury	f 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how	injury occurred
Division of Vital Records, all or Attending Physician: The law requires the safter death.  A filer this certificate has been signed in Director: After this certificate has been signed.	ed in by th	Certification: To	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of Inju	ury - At home, farm, str c. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
Divisio  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A	pletely filk	Medical C			f examination and/or in	h occurred at the time, date and plane occurred at the time, date and plane occurred in my opinion, death occurred in the control occurred in the cont		use(s) and manner as stated. e and place, and due to the cause(s)
To ti withi	com	Σ	29b. Signature and title of certifier	ND Dop	aty	29c. License number		d. Date signed (Month, Day, Year)
		4	30. Name and address of person when the state of the stat	o completed cause of d	eath (Item 23a) (Type,	Print)	ille Mi	21093
	Stat	e	31. Date filed (Month, Day, "Year) —	32 Pegistr	ar's Signature	and I	1	<u></u>
DHMH 17 F	egistra Rev 1/20		JANU82	UIU Lekw	v p. p.		-	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | () For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oglesby Jones Jewel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Union Memorial Hospital Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 🗆 M 💥 🗆 Months Days Hours Min. 220-14-1365 Director 89 GA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director NA Baltimore MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21211 U.S.A. 105 Providence Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 XWidowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Home Liasion Worker Public Schools 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sallie Harper Drew Oglesby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Md 21211 105 Providence Street, Gregory Jones-Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/12/10 Arbutus Memorial Arbutus, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

Yarch F/H West

4300 Wabash Ave, Tala Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner YONAYU Esque Hany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): the attending physician and ned for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown plnods 24b. Were autopsy findings available prior to completion of cause of death? Idvance 24a. Was an s certificate has t lirector, page 2 s performed? Yes 2 XNo 1 Yes 2 No **Division of Vital** eral irector After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 뎯 1 Tes 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5  $\square$  Pending 1 Tes 2 No fter death. Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours

To the Funeral D

completed filled i Medical 1 A Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address man 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 2, 2ბზნ William Norman King 7:30 A.<sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Cockeysville 10607 Lancewood Road 8. Date of Birth (Month, Day, Y July 29, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** , 1929 Baltimore, Maryland Months Days Hours tyDxM 2□ F 214-26-4619 80 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. And the Health and Mental Hygiene. The Hear 27 is marked other than "natural", or items 23a or 28a-f show my or other traumatic event, Pr. Medical Engine. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Cockeysville Maryland Baltimore Director 1 ☐ Yes 257 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States 21030 10607 Lancewood Road Funeral of America 12. Was Decedent Ever in U.S. Armed Forces? ↑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates: 1 ☐ Yes 2 ◯ No Specify: 2 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry
Baltimore City (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) Fire Department Firefighter 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred C. King ပ္ unk. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip\_Code) Jo A. King/ daughter 10607 Lancewood Road Cockeysville, Maryland 21030 permit. Pages 1 and:
Department of Health
Important: If Item 27
any injury or other tr.
once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p January 4, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examine Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Day Year 5 Other (specify) sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar autopsy performed certificate 2 No 1 ☐Yes 2 1NO completely filled in by the funeral director, 25. Was case referred edical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 12 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Mann Death after death. 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 and manner stated 29b. Signature and title of codifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Place HKUGGSI 31. Date filed (Month

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY **Physician** 10:30 PM 09 3010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours 404-30-2718 Director July 23, 1928 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ? is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Wedeal Examinating the notified at MD Baltimore 1 ☐ Yes 2√∑ No Sparrows Point Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2 should be filed within 72 hours after death with to and Mental Hygiene. 2825 Large FArm Road #325 21219 by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritai Status 1 ∐Yes 27∏No if Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) haker food industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George W. King Lee Dalton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau Dorothy Kitchen/cousin 412 Roseman Hgwy Brevard, NC 28712 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of annual Strice Licensee Wade Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate C use (Final disease or condition resulting in death)

a. RESTRATOR FAILURE Approximate Interval Between Onset and Death **Physician** 10 minutes /Medical Due to (or as a consequence of): Examiner > 10 years HEART ONDESTIVE squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine > 10 years law requires that the death certificate be executed DBSTRUCTIVE PULMONARY burial-tran and Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical guipt 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed After this certificate 2 ⊠No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred after death.

Director: After de in by the funera 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours are To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

NA 31. Date filed (Month, Day, Year) **JAN 0 8 2010** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Kohina M



4940 EASTERN AVENUE

JANUARY OX, 2010

21221

RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00218 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **FLORENCE** 12.00 KELMENSON Medical 01 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth Birthpiac Country) MD 1 □ M 2 🗓 F Days Months Hours 03/28/1922 **Director** 216-18-6513 87 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 X Yes 2 No BALTIMORE MD N/A 10e. Street and Number b 10f, Zip Code 10g. Citizen of What Country? pe 23a items 23a ler must b 21218 4000 N. CHARLES STREET, #903 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) SPEECH PATHOLOGIST SPEECH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ NEIMAN ISRAEL **ESTHER** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1759 MONKTON FARMS DRIVE, MONKTON, MD 21111 JOHN KELMENSON / SON 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 1/7/2010 REISTERSTOWN, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Sepsis Onset and Death Physician/ disease or condition resulting in death) as a result 5 Days Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 L Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Pregnant at time of death Month signed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: ည 1 Manpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at hours after death. Ineral Director: After 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours a
To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

Union Memorial

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

29c. License number

AT-2438946-A20

Hospital

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			Please T					Ensure Allealth and M		i <b>re Legible.</b> ene	
	1	For State Registrar		Otate of I	iviai yiai i		tificate of L			g. No. 2	00219
Physicia		1. Decedent's Name (Fin	st, Middle, Last)						Date of Death     Month	Day Year	
Physicia /Medica		Walter Lot					41- O't- T	Leasting of Dooth	January	1, 2010 4c. County of De	2:15 AM M
Examine	r	4a. Facility Name (If not Seasons Ho	-			ftal	Randal	Location of Death		Balti	
Funeral Director		5. Social Security Number	er 6. Sex		Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country) rvland
σ		Usual Residence of Dec	edent						mag 50;	1750 1114.	10d. Inside City Limits
arylan show	_	10a. State 10b	County		1	Town or Loc 1timor					11√2 Yes 2 □ No
the Mi	Director	10e. Street and Number			Da	T C TINO I	10f. Zip Code		10	g. Citizen of What (	
3a or	<u></u>	5011 Over	ton Stre	et				1229		USA	
	by Funeral	11. Marital Status 1   ↑ Never Married	2□ Married	2. Was Decede Armed Force 1 Tyes 2 If Yes, Give	es? <b>X</b> ]No		Vas Decedent of H f Yes, specify Cuba □ Yes 2X No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, lite, etc. white
hours		3 Widowed 4	Divorced  Decedent's Educ	Ye ar or Date	es:	16a. Deced	lent's Usual Occup	ation		6b. Kind of Busines	s/Industry
a. B. In "na	Completed		nly highest grade		or 5+)	(Give life. L	kind of work done of NOT use retired	during most of work d)	king		
ygiene rgiene er tha	E	12	y (0-12)	Ö	0, 01,	self	employe			gardner	-
uld be file Mental Hy Irked oth	lo Be	17. Father's Name (First Paul Lot							e (First, Middle, M de Anna P		
nd 2 sho alth and I 27 Is ma ar trauma		19a. Informant's Name/ Kristen T.			đ	19b. Mailir Rt	g Address (Street L Box 104	and Number or Rui A Wallace	ral Route Number, e, WV 264	City or Town, State 48	e, Zip Code)
Pages 1 annent of He Int: If item Iry or othe		20a. Method of Dispositi 1 ☐ Burial 2 ☐ Cr 4 🖾 Donation 5 ☐	emation 3 R	emoval from St	Cé	lace of Dispo emetery, cren	sition (Name of natory or other plac		Date 2	Oc. Location - City	or Town, State
permit. Departn Importa any inju		21. Signature of Funera	I Service License	ade, Ni	rector	St	Name and Addre ate Anate 1timore,	omy Board		Baltimore	Street
Physician		23a. Part 1. Enter the di shock, or heart fai Immediate Cause (Fina	lure. List only or	cations that cause on each	used the death ch line.		er the mode of dyir	ng, such as cardiac		st,	Approximate Interval Between Onset and Death
Physician /Medical Examiner		disease or condition resulting in death)		Due to (or	r as a consequ	ience of):	Conj	Conce	<i></i>		700
ted nsit	xaminer	Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injur	iate	Due to (or	r as a consequ	ience of):					
w L		that initiated events resulting in death) Last		Due to (or as a consequence of):							
tificate be e	ğ			l							
Attending Physician: The law requires that the death certificate be or death. ector: After this certificate has been signed by the attending physicia by the funeral director, page 2 should be detached for use as the bur	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								delivery Day Year	
w requires that the state of th	d by Ph	Part II. Other significan	it conditions cor	ntributing to dea	ith but not resu	ulting in the u	nderlying cause giv	ven in Part 1.			e to the cause of death?  Probably 4  Unknown
: The law req	Completed								24a. Was ar autops perform	y prior ned? death	autopsy findings available to completion of cause of 1?
sician: Th certificate rector, pag	Be	25. Was case referred texaminer?	-						th (Check only one	9)	
Physic this ce al dire		1 ☐ Yes 2 No	H	77.0	patient 2		IL 3 LI DOM			nce 6 Other (5	Specify)
ending Ph sath. or: After th he funeral	ation:	2 Accident	Pending investigation		, Day, Year)	28b. Time o Injury	M 1	ry at rk? ]Yes 2 □ No		w injury occurred	
al or Atters as after de	Certification: To	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place o building	of Injury - At hogg, etc. (Specif	ome, farm, str y)	reet, factory, office		28f. Location (St. City or Town	reet and Number or , State)	Rural Route Number,
	Medical (	29a. Certifier 12 (Check only 2 one)	Certifying Phy Medical Exami	sician: To the base ner: On the base and manner	sis of examina	wledge, deat tion and/or ir	h occurred at the to exestigation, in my	ime, date and place opinion, death occu	e, and due to the curred at the time, d	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
To th To th comp	Ĭ	29b. Signature and title	of certifier				29c. Licens	se number	2:	9d. Date signed (M	

State Registrar St

21136

30. Name and address of person who competed cause of death (Item 23a) (Type, Print)

SF ZWH MD Z5 Maw

31. Date filed (Marth Day 2010)

32. Registrar's Ignature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 7:05 A M Ngoc Lanh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death **Examiner** Montgomery 13907 Bromfield Road Germantown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Davs Hours February 4, 1938 579-02-6662 Director 71 Vietnam Usual Residence of Decedent shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛛 No Montgomery Germantown Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20874 United States 13907 Bromfield Road death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married 72 hours after 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Asian "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tailor Garment Industry other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file nent of Health and Mental I ant: If item 27 is marked o ၉ Men Van Le Cho Thi Ho 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13907 Bromfield Road, Germantown, Maryland 20874 Muoi Doan / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot January 8. 1 🖁 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2010 Parklawn Memorial Park Rockville, Maryland 21. Signature of Fureral Frvice Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. Mysecular M01305 300 West Montgomery Avenue, Rockville, Maryland 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (of as a consequence of). burial-transi Status Post Liver Transplant Due to (or as a consequence of): ŵ resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as t IF FEMALE: Jse yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy ŏ in the past 12 months? Month the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be i Heptocellular Carcinoma due to Chronic Hepatitis B 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 🗌 Yes 2 🕅 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA After this funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director, A M Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t determined To the Hospital Medical 1 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 3 🗆 Certifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Wark D0023429 January 5, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 New Hampshire Ave., Ste. 310, Takoma Park, MD 20912

Registrar

State

Ton That Chieu, M.D.

JAN 0 8 2010

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of M	arylan		artment of tificate of		ind Me		giene Reg. No.2	010	00221
	Physicia		1. Decedent's Name (First, Middle, Angeles Madorrar	,	a.k.a	Angeles	Madorran	Los Sant	toc	2. Date of Dea Month Januar		2010 Year	3. Time of Death 3:00 P M
	Medic Examin		4a. Facility Name (if not institution, g			<i>"</i>	4b. City, Town,		f Death	Januar	4c. Co	unty of Deat	th
			3210 North Leist  5. Social Security Number   6			#107 st birthday)	Silver If Under 1 Yea	Spring		8. Date of Birt		ntgome	ery thplace (State or Foreign
	Funeral Director		561-56-5858	1 □ M 2 🖺 F	94	Yrs.	Months Days			lovember	3 <b>,</b> ¶915	ိ်င်္ဂြိ	untry) pain
	ind ihow at	'n	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Loc	eation						10d. Inside City Limits
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	ith the 3a or 3	ralDi	10e. Street and Number 3210 North Leis	uro World B	1 v.d :	<b>#</b> 1∩7	10f. Zip Code 209	06				of What Co	*
	eath w tems 2 er mus	Funeral Director	11. Marital Status	12. Was Decedent B		i. 13. V	Vas Decedent of	Hispanic Origi	in? (Speci	fy Yes or No-	1	Race - Ame	rican Indian,
36	after d al", or i xamin	by	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	If Yes, Give	No		Yes, specify Cul		Puerto Ri	can, etc.)	Spe	Black, White ecify: Wh:	
2-00	hours "natura dical E	plete	15. Decedent' (Specify only highest				ent's Usual Occu		of working	,	16b. Kind	of Business	Industry
121	ithin 72 ene. r than '	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	5+)	life. DO	NOT use retired Maker	d)	o, worthing	'	Garme	ent In	dustry
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be	17. Father's Name (First, Middle, La.	st)						First, Middle,	Maiden Surr		
ıryla	d 2 should be file alth and Mental H 27 is marked o r traumatic eve	2	Juan Losantos  19a. Informant's Name/Relationship	(Type Print)	_	10h Mailin	g Address (Stree	<u> </u>		adorra:		un Stata 7ii	n Cada)
, Ma	id 2 sheath ar n 27 is er trau	ij	Josefina T. Pop		r		3 Vandev				-		ryland 20833
ore	ge 1 an nt of He : If iten or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		20b. Pl	lace of Dispos	sition <i>(Name of</i> Ptory or other pl Reaven Mausole	<sub>ace)</sub> J		ry 8,		_	Town, State
altim	mit. Pa bartmer bortant r injury		4 ☐ Donation 5 ☒ Other (Sp 21. Signature of Funeral Service Lic		ıţ cei	metery	Mausole  Name and Addi	ess of Facility	2010 Robe	rt A.	Lumphi	r Spri rey Fu	ng, Maryland neral Home/ Avenue
ñ	permit Depar Impor any in		Logan	nact .	10149							omery	Avenue
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	Examiner	e	Sequentially list conditions,	b. Due to (or as	a consequi	ence off:							
V	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events	C.	a consoqu	0.100							
4	ate be executed physician and the burial-transit		resulting in death) Last	Due to (or as	a consequ	ence of):							
3760	ficate by g phys	Medical		d									
Box 68760	eath certific attending p	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 - Fetal	I death 3	Ectopic pregna	ncy			23d	I. Date of de Month	livery Day Year
Bo	the dea by the a ached f	Physician/M	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of a	eatn 5∟	Other (specify)						Day Ioa
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ords	v require s been si should b	leted								24a. Was a			topsy findings available
Rec	sician: The law certificate has k lirector, page 2 s	Completed								autop perfor 1  Yes	rmed?	death?	completion of cause of
ital	ician: certific rector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:			In	Place of Death		only one)			
of V	• Attending Physician: The le or death. • ector: After this certificate he by the funeral director, page	te: To	27. Manner of Death	1 ☐ Inpati	ry	ER/Outpatien 28b. Time of injury	28c. Inju	4 ∐ Nur uryat		e 5 🔀 Resid id. Describe h			ify)
ion	tendin Jeath. tor: Aft the fur	Certificate:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investiga 3 ☐ Sulcide 6 ☐ Could no	ation			M 1	rk? ☐ Yes 2 ☐ N					
Division of Vital Records,	al or Attends after deat   Director:		4 Homicide determin				et, factory, office		28	If. Location (S City or Town		umber or Ru	ral Route Number,
^	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transitions.	Medical	(Check 2 L Medical Ex		xamination	and/or invest	igation, in my opii	nion, death occ	curred at th	ne time, date ar	nd place, and	d due to the	cause(s) and manner stated.
7	To the within to the comple	Ž	only one) 3 L Certifying N 29b. Signature and title of certifier	Nurse Practioner: To the	best of my	knowledge, c		the time, date a	and place,			gned (Month	
			1 Clusto	Jagnur	7			793			Janua	ry 5,	2010
_			30. Name and address of person with Christopher J.	Mays, M.D.	181	ll Pri	nce Phil	lip Dr.	#20	7, Oln	ey, Ma	arylan	d 20832
	Stat Registra	ie ar	31. Date filed (Month, Day 2010)	Ac 32. Registra	ar's ignati	park							

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	ryland /		rtment of F tificate of I		Mental Hy	giene /	2010	00222
	Physicia	an	Decedent's Name (First, Middle,		161	, ,	2-110		2. Date of De		Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution,				4b. City. Town, or	Location of Death	01	4c. Co	ounty of Death	
			201011	EHABILITA	TION	, ,	Trunder 1 Year	ARE BA			O Dint	(0)
	Funeral Director		5. Social Security Number 218–16–9338	5. Sex 12 M 2 □ F 7. Age	e (In yrs. last b 86	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D Aug	ay, Year)	Cou	place (State or Foreign ntry) nnsylvania
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	wn or Loc	ation					10d. Inside City Limits
	a-f sho	ctor	MD Talb	oot	Eas	ton						1 ☐ Yes 2 No
	/ith the	Director	10e. Street and Number				10f. Zip Code			•	en of What Cou	,
	ns 23a	Funeral	8517 Miles Ct.	12. Was Decedent E	Ever in U.S.	13. W	21602 as Decedent of H	L ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or N		. Race - Ameri	ican Indian,
326	vithin 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f show at Medical Evn clinar must be indiffed at	by Fur	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces?  1 XYes 2 □ N  If Yes, Give  Year or Dates:	WW II		Yes, specify Cuba □Yes 2 <b>⊠</b> No	n, Mexican, Puerto Specify:	o Rican, etc.)		Black, White, pecify:	etc. White
5-0036	72 hou natura		15. Decedent's (Specify only highest	Education		(Give k	ent's Usual Occup	during most of work	king	16b. Kind	of Business/Ir	ndustry
2121	vithin ene. <b>than</b> "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. D	ONOT use retired olster	()		Fr	ee Land	ce
		BeC	17. Father's Name (First, Middle, La					18. Mother's Nam	ne (First, Middle	, Maiden Su	urname)	
Maryland	uld Mer arke	ဥ	William McCle  19a. Informant's Name/Relationshi		10	ah Mailine	Address (Street	Elizab and Number or Ru		nnely	Town State 7	in Code)
	nd 2 sulth an 27 is r trau		Daisy McClella									MD 20744
altimore,	S = = 0		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Special Control of the Control				ition (Name of atory or other place ike Crema	1	Date Jan 08 2010	,	ation - City or To	own, State
Baltıı	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Li		Mois	1 22		Sh <sup>of</sup> Endly Fun				
	TO = # 0		23a. Part 1. Enter the disease, or c	omplications that caused	the death. Do	o not ente		en Pasture ng, such as cardiac			n Maryl	Approximate
	Physician /Medical	0	shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause on each lin  a.  Due to (or as a	CINA	MA	LUM	16 M	ETA	STA	Tie	Interval Between Onset and Death
	Examiner		Sequentially list conditions,	b.	a consequence	e 01).						
١.	nsit	niner	ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequence	e oij.						
0, U	ficate be executed physician and s the burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a	a consequence	e of):						
68760	ficate t physic s the b	edical		d								
O. Box (	The law requires that the death certific lie has been signed by the attending p age 2 should be detached for use as t	Physician/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No	23c. If yes, outcome  1  Live birth 4  Pregnant at 9  Unknown	2 Fetal dea		Ectopic pregnanc Other (specify)	у		23	d. Date of deliving Month	very Day Year
, P.	v requires that the de been signed by the should be detached		9 ☐ Unknown  Part II. Other significant condition			in the un	derlying cause giv	en in Part I.	23e. Did	tobacco use	e contribute to	the cause of death?
Srds	equires sen sigi ould be	ted by	CHRONIC	OBSTRIC	TIVE	H	LMONT	187 NE	15 10	Yes 2□	No 3 ☐ Pro	obably 4 🕅 Unknown
Division of Vital Records,	The law rate has be	Completed							24a. Was auto perf 1 □Yes		24b. Were aut prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2  ☐ No
Vita	sician: The la certificate ha rector, page 2	Be	25. Was case referred to medical examiner?	Hospital:			3□ DOA Oth	26. Place of Dea	th (Check only	1.		
o	g Physter this neral di	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injur	ry 2 ER/C	Outpatient  Time of Injury	3 ∐ DOA 28c. Injur Worl	4 pc Nursing H	ome 5 ☐ Res 28d. Describe			ify)
Sior	tendin leath. tor: Af the fur	catio	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	ation			M 1 🗆	Yes 2 □No	006	101 1		1 Oc. 4: North
	al or At after of Direct of in by	Certification: T	4 ☐ Homicide determin		ry - At nome, c, (Specify)	tarm, stre	et, factory, office		City or To	(Street and wn, State)	Number or Hui	ral Route Number,
	To the Hospital or Attending Physician: within 42 hours after death.  To the Funeral Director: After this certified completely filled in by the funeral director, p.	Medical C		p Physician: To the best of examiner: On the basis of and manner sta	f examination a							
	To the within To the compl	Me	29b. Signature and title of certifier	1 110-1	7 .	21 /	29c. Licens		4		signed (Month	
	\		Pohen 9	to complete				1648				
	4+1		30. Name and address of person was selected and address of person was selected. A selected and s	SHM S MO	390	D C	THE PA	VEN BLI	VD BK	ZTHE	WAE.	MD 21218
	Sta Registr		31. Date filed (Month, Day, Year) JAN 08	2010 32. egistra	ar's Signatur	A	ge No.					

DHMH 17 Rev 1/2001

State

Registrar

54.00 old

31. Date filed (Month, Day, Year)

JAN 0 8 2010

Court Road

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7, Day 2010 ear Janth Muffoletto Sr. Anthony A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Essex Baltimore Riverview Nursing Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Februs, D3, Yerr918 1 ★ M 2 🗆 F Days Hours 91 215-09-9789 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. Count 10a. State 10c. City, Town or Location Director Baltimore MD Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1631 Turkey point Road 21221 Hygiene. other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Examiner Completed by 1 Never Married 2 Married 1 XYes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 XWidowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Master Plumber State of MD 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be file f Health and Mental F item 27 is marked of ဂ္ Culotta Salvatore Muffoletto Concetta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1631 Turkey Point Road Baltimore MD 21221 daughter Rita McCamm or other item 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place, Holy Redeemer 1 Durial 2 Cremation 3 Removal from State 1/9/10 Baltimore MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licepse 22. Name and Address of Facility Name and Address of Facility 300 Mace Ave. Balte Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Examiner Due to (or as a consequence of): and -transit Due to (or as a consequence of): resulting in death) Last bunialattending physician for use as the buria Physician/Medical that the death certificate be 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box ( in the past 12 months? Yes 2 No ed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. is certificate has been signed director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Too 24a. Was an autopsy performed? Yes 2 Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one 29b. Signature and title of certifier 29c. License number MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NASERM.

31. Date filed (Month, Day, Year).

709.

32. Pesistrar's Signature

BASTERM

3. Time of Death

Birthplace (State or Foreign Country)

Balto. MD

Approximate Interval Between Onset and Death

MD

10d. Inside City Limits

1 Yes 2 X No

5:45a<sub>M</sub>

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State State Registrar		artment of Health and ertificate of Death	Mental Hygier	2010 00000
			1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physici /Medio		Eun Soon Moon				Day 4, 2010 1:55 P. M
100	Examin		4a. Facility Name (If not institution, give street and r	number)	4b. City, Town, or Location of Deat	h .	4c. County of Death
met.			Stella Maris		Timonium		Baltimore
ı	Funeral Director		5. Social Security Number 6. Sex 1 M 2 T F	7. Age (In yrs. last birthday) 101 Yrs.	If Under 1 Year   If Under 24 Hrs   Months   Days   Hours   Min.	(Month, Day, Yea	9. Birthplace (State or Foreign Country)  908 Korea
	nd ×		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or L			
	sho	2		,			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	the N	Director	Maryland Baltimore  10e. Street and Number	Towso	n 10f. Zip Code	100	Citizen of What Country?
	aa or		617 St. Francis Road		21286	109.	
	death	Funeral	11 Marital Status 12. Was De	cedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	U.S.A.  14. Race - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a fired Event, and independent of the profit of the fired fired fired.	by Fu	1 Never Married 2 Married 1 Yes	Give No	If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 No Specify:	to Rican, etc.)	Black, White, etc.  Specify: Voncon
21215-0036	hour	ed b	3 Widowed 4 ☐ Divorced Year or  15. Decedent's Education		edent's Usual Occupation	16h	Korean  Kind of Business/Industry
215	nin 72 n. "na n. "na	Completed	(Specify only highest grade completed	d) (Give	e kind of work done during most of wo DO NOT use retired)	rking	. Time of Businesser industry
21	d with giene	E O	8 years	(1-4or 5+)	Homemaker		Own Home
D D	tal Hy d other	Be (	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maid	len Surname)
<u>ya</u>	Meni Meni arrke	ပ	unk Hong		unk	Pak	
Maryland	2 should h and Mer r is marke raumatic		19a. Informant's Name/Relationship (Type. Print)		ing Address (Street and Number or R		
	1 and Health em 27 ther ti		Helen Wang (daug)  20a. Method of Disposition		St. Francis Road		ryland 21286  Location - City or Town, State
o D	Pages nent of int: If ite iry or o		1 ☑ Buria! 2 ☐ Cremation 3 ☐ Removal from	n State	osition (Name of matory or other place)		•
altimore,	artme ortan injur		4 Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Dulaney Va.	LLCY I LIII OLULUS .		monium, Maryland
ä	permit. Departr Importa any injt		I Joseph Ferras	<i>→</i>	2. Name and Address of Facility Mitchell—Wiedefel 6500 York Road	d Funeral I Baltimore,	Home, Inc. Maryland 21212
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on	t caused the death. Do not en			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	NA STAGE	DEMENTIA		Onset and Death
فتحث	/Medical		resulting in death)	o (or as a consequence of):	001107 111		
	Examiner	_	Sequentially list conditions, b.				
	ted	Examiner	cause. Enter Underlying Cause (Disease or injury	o (or as a consequence of):			
_#^	execu al-trar	xan	that initiated events c	o (or as a consequence of):			
8760,	cate be executed physician and the burial-transit		d				
Ö	tificat ng phy as the	fedical					
Box	eath certifi attending   for use as	an/In	23b. was decedent pregnant	outcome of pregnancy e birth 2  Fetal death 3	☐ Ectopic pregnancy		23d. Date of delivery
0	at the dea by the at tached fo	Physician/M		egnant at time of death 5	Other (specify)		Month Day Year
σ.	hat th ed by detach	Phy	Part II. Other significant conditions contributing to	death but not resulting in the u	inderlying cause given in Part I	23e. Did tobaco	co use contribute to the cause of death?
Records,	The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	d by				1 □ Yes	2 No 3 Probably 4 Unknown
၀ ဂ	aw requir as been s 2 should	Completed				24a. Was an	24b. Were autopsy findings available
	: The lav cate has page 2 :	mo				autopsy performed 1 □ Yes 2	prior to completion of cause of death? No 1 □ Yes 2 □ No
Vital	sician: The certificate I rector, page	Be C	25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)	12100 2210
<u>&gt;</u>	hysic this or		1 Yes 2 No Hospital: 1 □	Inpatient 2 ER/Outpatie		lome 5 ☐ Residence	e 6 ☐ Other (Specify)
Division of	ling F	ion:	1 Natural 5 Pending (Mo	te of Injury 28b. Time onth, Day, Year) 1njury	Work?	28d. Describe how in	njury occurred
S	death death stor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be	ce of Injury - At home, farm, st	M 1 □Yes 2 □No	20f Location (Street	and Number or Rural Route Number,
<u>&gt;</u>	after Direction by	Certification: To	4 Homicide determined buil	ding, etc. (Specify)	reet, factory, office	City or Town, St	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director; p		29a. Certifier 1 Certifying Physician: To the	he best of my knowledge, dea	th occurred at the time, date and place	e, and due to the cause	e(s) and manner as stated.
	the Ho nin 24 the Fu	Medical	one) X NURSE PRACE	Prof. state NER	nvestigation, in my opinion, death occ	urred at the time, date	and place, and due to the cause(s)
	To To	2	29b. Signature and title of certifier	2	29c. License number	29d.	Date signed (Month, Day, Year)
	0		JAXINGERNT		1449192		152010
	FV		30. Name and address of person who completed ca	use of death (Item 23a) (Type; 2 <i>300 DULANEY V</i>		IIUM, MD 21	093
	Sta	te	JACKIE JONES, CRNP 2 31. Date filed (Month, Day, Year) 2 32.	Registrar's Signatus		10H, M 21	
	Registr		JAN 0 8 2010 Reser	A B. 11-			

JANUARY 4, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** William Anthony McCarty 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Under 1 Year | If Under 24 Hrs. Hospital of Bo Hunore 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number . Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Months Days Hours 83 212-22-1148 Director July 10, 1926 Usual Residence of Decedent death with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, it a Medical Evanimer must be notified at 1XXYes 2 □ No Maryland N/A Funeral Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3855 Greenspring Ave. 21211 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: ₩₩ II Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 No Specify: ģ Specify: white 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 salesman dairy company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Heatth and Menta Important: If item 27 is marked any injury or other traumatic evonce. James E. McCarty Rita Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kendall McCarty/daughter 194 Church St. Waltham, MA 02452 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory Jan. 7,2010 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee John O. Mitchell IV, Funeral Services of Dulaney Valley 200 E. Padonia Rd. Timonium, MD 21093 P.A. Lohn O. Mitchell 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of). disease or condition resulting in death) /Medical Examiner Sequentially list conditions, it any, reading to infine liate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 □ No s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an his certificate h I director, page estue 1 □ Yes 2 🖳 Ko 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the

State

Registrar

son who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ J<sup>Month</sup> January 5<sup>Day</sup>2010 4:53P Virgil Mullenax Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Balto. Nottingham 8343 Cypress Mill Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) December 7, 1919 Social Security Number Sex 1X M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Min. Hours West Virginia Director 90 234-22-0676 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Nottingham Md. Balto. 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21236 USA 8343 Cypress Mill Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces?
1 ☐ Yes 2X No Black, White, etc. 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Union 486 Steamfitter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sylva Wilfong Ona Mullenax 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 8343 Cypress Mill Rd. Nottinghma, Md. 21236 Edwina L. Mullenax Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-9-2010 Bayview Balto. Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ nronce Medical Due to (or as a consequence of) Examiner 29 to Fecunitally list no differs if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami the attending physician and hed for use as the bunal-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes 2 No Completed should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performe 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No M Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 007465 010

State Registrar 30. Name and address

31. Date filed (Month, Day, Year)

Jeffrey Cool MD.

9712 Belair Road

Nottingham, Md, 21236

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1- Registrar Registrar Registrar Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** JAN. 05, 2010 3:40 P M JOHN E. MYERS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** DUNDALK

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

SEPT. 9, 1918 FUTURE CARE NORTH POINT BALTIMORE 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 91 MARYLAND 220-09-8592 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Marifical Evantian countries. 10a State 10b. County 1 ☐ Yes 2X No Director MD. BALTIMORE COLGATE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 UNITED STATES 7728 WYNBROOK RD. Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married WHITE 1 ☐ Yes 2 XNo Specify: Specify: ş 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MORTGAGE DEPT. OF BANK 12 TH VICE PRESIDENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN MARTIN MYERS KATE UNKNOWN ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7728 WYNBROOK RD., BALTIMORE, MARYLAND CATHERINE MYERS/WIFE 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 01/10/2010 GLEN BURNIE, MARYLAND ATLANTIC CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funer Service Licenset 6224 EASTERN AVE., BALTIMORE, MARYLAND Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease of complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner TON MERCHED BY MEDICAL EXMINIER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-trar Due to (or as a consequence of): attending physician Physician/Medical CERTIFIC as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Intractanial bleeding 23e. Did tobacco use contribute to the cause of death? Þ sign I be an Ux 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed due to stroke. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after dealy.

To the Funeral Director: After this certificate has! completely filled in by the funeral director, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 🖽 No 25. Was case referred to medical examiner?

1 X Yes 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

requires that the death certificate be executed P.O. Records, Vital of Division Hospital or Attending

filed within 72 hours after death with the Maryland

Baltimore,

ayed

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

M-1)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signature and title of certifier



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

BLUD.

29d. Date signed (Month, Day, Year)

01-07-2010

MD-21221.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** BARTHOLOMEW STEVE MATASOVSKY 2010 1:44 Α JANUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER BEL AIR
If Under 1 Year | If Under 24 Hrs. HARFORD 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 TM 2 TF Director 212-20-7430 87 19. 1922 CZECHOSLOVAKIA APR. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo MARYLAND HARFORD ABINGDON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 803 Long Bar Harbor Road 21009 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify. Completed by Specify: 3 Widowed 4 □ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stockroom Supervisor Shoe Manufacturer and Mental Hygi 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Stefan (nmn) Matasovsky Terezia (nmn) Hric ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health of Hem 27 is Penelope Ekey / Daughter 710 Long Bar Harbor Road, Abingdon, Maryland 21009

e of Disposition (Name of Date 200. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages Department of Important: If It 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Injury 4 Donation 5 Dother (Specify) Highview Memorial Gdn 1-6-2010 Fallston, Maryland 21. Signatura Funeral Service Licenses McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one Lause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** dans /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2. No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

JAN 0 8 2010

Bartholomen masses

throad

ason Birnbaum, m.D. 6025.

32. Registrar's Signature

			101	State of Mar	ryland / Depa			Mental Hy	giene		00000
_			State Registrar		Cer	tificate of I	Death	T	Reg. No. 2	10	00230
	Physicia	n/	1. Decedent's Name (First, Middle, Last)  ERNEST LEON	ACCORMI	CK			2. Date of Dea		Year 3010	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give str			4h City Town o	r Location of Death	1 "	4c. County		07.3( A M
	Examin	EI	HARGOR HUSPITA	,		BALTI			4c. County	or Death	
	Funeral		Social Security Number     6. Sex	7. Age (/	In yrs. last birthday)	If Under 1 Year Months Days	,—	8. Date of Birt			place (State or Foreign
	Director		218-44-6190   1XJ	M 2 🗆 F	63 Yrs.	Wortins Days	Tiours Willia.		4 46	Coun	NC NC
	and show at	or	10a. State 10b. County	1	Oc. City, Town or Lo				10d. Inside City Limits		
	Maryla 18a-f	Director	MD NA		Balti	more					1 Yes 2 No
	a or 2	iO le	10e. Street and Number	1	* *	10f. Zip Code			10g. Citizen of W		•
	th with ms 23 must	Funeral	632 Cheraton Ro				21225		U	. S . F	١.
	or iter	by Fu	11. Marital Status  1 Never Married 2 Married	2. Was Decedent Eve Armed Forces?			lispanic Origin? (Sp an, Mexican, Puerto			- Americ k, White,	ean Indian, etc.
20	rs afte	q pa	3 Widowed 4 Divorced	Yes 2 No If Yes, Give Year or Dates.	,	1 ☐ Yes 2 🛣 No	Specify:		Specify:	E	Black
21215-0036	s filed within 72 hours after death with the Maryland tral Hygiene.  ad other than "natural", or items 23a or 28a-f show event, the M. dir al Examiner must b. notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)		dent's Usual Occup	oation during most of worl	kina	16b. Kind of Bu	siness In	dustry
121	thin 7:	)om	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	O NOT use retired)		wing .	Cloopi	na G	Service
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<u>lan</u>	l be fil lental rked tic ev	욘			Ollk	CHOWH	Annie I		,		
Maryland	12 should be filed with alth and Mental Hygien 27 is marked other ti r traumatic event, the	1	19a. Informant's Name/Relationship (Type	, Print)	19b. Mailir	ng Address (Street	and Number or Rui				Code)
∑.	5 E 6	1	Michelle McCormic	ck-Wife	632	Cherato	on Road	Balti	.more,	Md 2	21225
_	ge 1 a		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State		natory or other plac		Date	20c. Location -	-	
<u>=</u>	it. Page irtment o irtant: If injury or		4 Donation 5 Other (Specify)		Garrisor			/11/10	Owing	s Mi	ills, Md
Вa	permit. Page 1 a Department of H Important: If ite any injury or ott		21. Signature of Funeral Service Licensee	211/	Ma	Name and Addre	H West				
			23a. Part 1. Enter the disease, or complic	ations that caused th			ash Ave			Maz.	Approximate
-	nysician/	6	shock, or heart failure. List only one Immediate Cause (Final disease or condition		OMYOPATH	, ( DTL	ATED				Interval Between Onset and Death
	Medical		resulting in death)	Due to (or as a c		CDT	7100				TYEARS
	Examiner	<u>.</u>	Sequentially list conditions, to								
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	executed an and rial-transi	Еха	that initiated events c. resulting in death) Last	Due to (or as a c	onsequence of):					_	
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9/89	death certificate In attending physed for use as the	Med	IF FEMALE:	\							
٥ ×	th cer ttendil or use	ian/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of 1 Live Birth 2	☐ Fetal death 3 ☐	Ectopic pregnan	су		23d. Date		
BOX	the a	Physician/Me	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at ti 9 ☐ Unknown	me of death 5 ∟	Other (specify)			Mor	itn	Day Year
л Э			Part II. Other significant conditions conti				ven in Part I.	23e. Did to	bacco use contri	bute to th	ne cause of death?
S,	law requires that the death certifics has been signed by the attending p e 2 should be detached for use as i	Completed by			MUNARY D			1 🗹	Yes 2 No	3 🗌 Prol	bably 4 🗆 Unknown
Š	w req	plet	ACUTE RENAL INSUF	FICIENCY, (	CHRUNIC A	TRIAL FI	BRILLATION	24a. Was a			psy findings available
He	The la ate ha page	Com			-			autop perfo 1  Yes	rmed? d	eath?	mpletion of cause of
<u>ra</u>	cian: ertific ector,		25. Was case referred to medical examiner?	spital:			lace of Death (Chec				
<u> </u>	Physi this c	<u>.</u> To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatient 28a. Date of injury	t 2 ER/Outpatier		4 L Nursing H		dence 6 Othe		)
0	ding th. After fune	cate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Y		work		28d. Describe h	ow injury occurre	đ	
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 is completed filled in by the funeral director, page 2.	Certificate:	3 Suicide 6 Could not be 4 Homicide determined		- At home, farm, stre				ion (Street and Number or Rural Route Number,		
	tal or rs afte al Dir led in			building, etc. (	Specify)			City or Tow	n, State)		
	Hospi	Medical	29a. Certifier 1 Certifying Physici (Check 2 Medical Examine)	an: To the best of my	y knowledge, death omination and/or invest	occured at the time	e, date and place, a	nd due to the cau	use(s) and manne	r as state	d. use(s) and manner stated.
	ithin 2 or the omple	Me	only one) 3 Certifying Nurse F  29b. Signature and title of ertifier	Practioner: To the be	st of my knowledge, o	death occurred at the	ne time, date and pla	ce, and due to the	e cause(s) and mai	nner as st	ated.
	≓ S F ŏ		Day & M	/ M.D	)	RES			JANVARY		
	1		30. Name and address of person who co	pleted cause of deat	th (Item 23a) (Type, P	Print)					
	Hr,		ANMOLDEEP S.	BAJAJ			HANOVER 3	ST, BAL	TIMURE,	MO	21222
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Red .					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 20 ANUAR21 HARLES MATTHEWS 04 201 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SECOURS HOSPIT AT BALTI MORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 F Director 215-34-9400 Oct.8,1937 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f shov the Medical Examiner must be notified at Director 1 √Yes 2 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 1300 E. Lanvale St. 21213 USA "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ģ 1 ☐Yes 2 ☐ No Specify. Specify.Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any Injury or other traumatic event, the Magnice. Elementary/Secondary (0-12) College (1-4or 5+) self employed various jobs 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Matthews Della Sharp ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Isabell Carter (sister) 1216 E. Eager St. Balto, Md. 21202 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Zion Cemetery Jan. 13, 2010 Balto, Md. Calvin B. Scruggs Funeral Home nature of Funeral Service Licenses 1412 E. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** EPTIC SHOCK disease or condition resulting in death) \* /Medical Due to (or as a consequence of): Examiner ELLULITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) ☐Yes 2 ☐No Ö 9 Unknown 9 Unknown signed by t ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ IMMUNDOFFICIENCY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed HEPATITIC 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☑ No 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Tripatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1√Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral [ 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 D302 72 JANUARY

State Registrar

DHMH 17 Rev 1/2001

BON

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MILLER

31. Date filed (Month, Day, Year)

1308 hrs If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Country) Virginia 10d. Inside City Limits 1 Yes 2 X No 14. Race - American Indian, Black, White 16b. Kind of Business/Industry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Washinton Avenue, Suite 900, Towson, MD. 21204 20c. Location - City or Town, State Baltimore, Maryland <sup>22</sup>Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk,Md. 21222 Approximate Interval Between Onset and Death Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of Nursing Home 5 Residence 6 ✔ Other: Scene Certification: within 24 hours after deaun.

To the Funeral Director: A 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E January 4, 2010 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar ANLOR OCME **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0903 Physician/ January 4, 2010 Darlene Marie Michalik Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday Funeral 1 □ M 2 🎛 F Hours Months Days February 15 1930 Ok l'affoma 79 440-26-7625 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🎦 No Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20852 United States 6110 Calwood Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc þ 1 Never Married 2 X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natuury or other traumatic event, the Medical ury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carl M. Lieber Rosemary Elizabeth Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6110 Calwood Way, Rockville, Maryland 20852 Thomas Michalik/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Carmetery, grematory or other place) Cemetery 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or Silver Spring, Maryland 4 ☐ Donation 5 ☒ Other (Specify) Entombment 22. Name and Address of Facility Robert A. Fumphrey Funeral Home/ R8EKVIIIE; Maryland 26850 Montgomery Avenue . Signature of Funeral Service Lipensee M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DICME Immediate Cause (Final ATHEROSCUEROTIC CARDOVALCUA Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury law requires that the death certificate be executed the burial-transit Exam and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 Other (specify) \_\_\_\_\_ in the past 12 morths?
1 Yes 2 No Dav Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performe To the Hospital or Attending Physician; The 2 No certificate 1 Tes within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 욘 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 M Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 310 -04-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul O'Brien, 8600 Old Georgetown Road, Bethesda, Maryland 20814

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 8 2010

32. Registrar's Signature

AMEND ITEM#1perPHYS G901 3/2/2010 WS State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)

James Lee Nadolsky

James Lee Nodolsky 2. Date of Death **Physician** 2010 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death Sauare her 6. Sex Hospital Lenici Balti Franklin da more 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral №** 2□ F Months Days Hours 186-32-3133 Director 68 06/20/1941 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23 or 28a-f show any injury or other traumatic event, If a Modifical Examination in the Indiana adonce. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Maryland Baltimore 1 ☐ Yes 2 No Essex Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 916 Sandalwood Road 21221 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 16 じららっして イン しのいたい Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Completed by Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Garment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Nadolsky Blanche Short 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Ramirez (Daughter) 916 Sandalwood Road, Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc 01/08/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line.

Immediat, cause (Final disease or condition resultion in death)

a. Clostical Approximate Interval Between Onset and Death **Physician** Weeks /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No Be ( 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63054 ANUARY 6, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAJIO CINA, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MARYLAND 21237 31. Date filed (Month, Day, Year) JAH 0 8 2010 37. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 20b per Ih g899 1-8-10 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician MARGARET M. PENN JANUARY 2010 10:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner STELLA MARIS HOSPICE BALTIMORE TIMONIUM 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1 □ M 2 🔽 F Months Days Hours 94 Vrs Director 214-01-3519 JULY 28,1915 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examirer must be notified at Director 1 XYes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5904 KAVON AVE 21206 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 | Yes 2 | No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WAITRESS CATERING 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental OLIVER CURNOLES ROBERTA LOWE ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 an ment of Heah nt: If item 27 ELAINE WAGENFUEHR-DAUGHTER 5904 KAVON AVE BALTIMORE, MD 21206 Itimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date  $\frac{1}{12}$   $\frac{10}{7}$ Department of Important: If any Injury or once. 1 X Burial 2 Cremation 3 Removal from State GARDENS OF FAITH BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR RD BALTIMORE, MD 21206 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure list only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): My siters we Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-trar be execu Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 687 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown nuer uns certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 1/154100 24b. Were autopsy findings available prior to completion of cause of death? autopsy Hospital or Attending Physician: The performed? Division of Vital 1 ☐Yes 2 ☐No 1 ☐Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 → Other: 4 Starting Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director; 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only within 2 To the 1 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 4, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) = 32. Strar's Signature

EDDIE NAKHUDA, M.D.

VAR 08 2010 July 1 July 1

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MARGARET

2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Rameshbhai **Patel** 10 03 atel 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore of Mazland
7. Age (In yrs. last birthday) Center Univ. Shock- Irama Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number **Funeral** Months Days Hours Min 1**X** M 2□ F 81-837 55 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 □Yes 2 No Director MD HDerdeer 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify: Specify: Indian Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Oved d marked other 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental tem 27 is marked o ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ŝ - 10 Hberdeen Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important; If it any injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Funera BCIAII 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility remainon 21. Signature of Funeral Service Licensee Funeral Chapel Services - 3 Newport Dr. Forest Itil mo. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 39 hours CENTIFICATION REPROVED BY MESTING ELIMINES Physician Intracrumal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last FALL Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and -trar Due to (or as a consequence of): burial-t Box 68760. physiciar Physician/Medical the. as IF FEMALE: nse If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? atten for us 3 🗌 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a ☐Yes 2☐No Ö 9 Unknown ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>2</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No has certificate 1 ☐ Yes 2 ☐ No After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 8a. Date of Injury
(Month, Day, Year)

OI - O2 - ZOIO

Representation of Injury

Found Opposition of Injury

One of Injury

On 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 □Yes 2 □No Fell backwards on within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Steps 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 238 Woodlown Executary Aberdeen 4 Homicide at home Outside 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 987 01-02-10 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultmore (munous and 22 2 24 3 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Ray Lee Pullen Sr. 2010 Jan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Westminster Carroll 544 Spruce Ave. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 **№**M 2 🗆 F 53 212-70-0992 5-19-1956 Director Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Westminster MD Carroll 1 ☐ Yes 2 ☑ No ral", or items 23a or 28a-f sh Examiner must be notified Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21157 USA 544 Spruce Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 22 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white ρ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pest Control Elementary/Secondary (0-12) College (1-4or 5+) Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Christine Reed Herman Lee Pullen Jr. ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 544 Spruce Ave., Westminster, MD 21157 Charmaine Pullen-wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
South Carroll C 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crem 1-5-2010Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of June al Service Licensee 22. Name and Address of Facility Fletcher Funeral Home 254 E. Main St., Westminster, MD 21157 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 8/07-present **Physician** Squamous Cell Carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exam g physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as 1 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4√2 Unknown certificate has been sirector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 🖾 No 1 ☐ Yes 2 ☐ No funeral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 2 ☐ ER/Outpatient 3 ☐ DOA မှ 1 Inpatient this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral I
completely filled 29a. Certifier 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0057256 January 4,2010 (unar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. Belvedere Ave., Baltimore, MD 21515 Pallari Ρ. Kumar, 31. Date filed (Month. Day. State

DHMH 17 Rev 1/2001

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of	f Maryland / Depa	artment of Health a	and Mental Hyg	jiene	
		•	1 - State Registrar	Cei	rtificate of Death	R	leg. No. 2010	00238
			1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month	th Day Year	3. Time of Death
	Physicia /Medic		Mary Catherine Johnsto	on Riffee		January	8, 2010	12:15 A.™
4	Examin		4a. Facility Name (If not institution, give street and nur		4b. City, Town, or Location o	f Death	4c. County of Death	
- and			Stella Maris		Timonium		Baltimore	
	Funeral			7. Age (In yrs. last birthday)	If Under 1 Year If Under 2 Months Days Hours	24 Hrs. 8. Date of Birth Min. (Month, Day	(Year) Country	ce (State or Foreign
	Director		190-28-2814 1□ M 2 <b>X</b> F	73 Yrs.		April 2		ylvania
	pu s		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or Lo	cation		100	I. Inside City Limits
	sho	5						1 ☐ Yes 2127 No
	28a-1	Director	Maryland Baltimore  10e. Street and Number	Timoniu	n 10f. Zip Code		10g. Citizen of What Country	/?
	with ta or							
	ns 23	era	2300 Dulaney Valley Ros	dent Ever in U.S. 13.	21093 Was Decedent of Hispanic Original	gin? (Specify Yes or No-	14. Race - American	ı Indian,
<b>'</b> O	r iter	Funeral	Armed Fo 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes	2 👿 No	If Yes, specify Cuban, Mexican	, Puerto Rican, etc.)	Black, White, etc	<b>&gt;</b> .
8	urs a	by	If Yes, Giv 3 ☐ Widowed 4 🔀 Divorced Year or D	/e	1 □ Yes 2 X No Specify:		Specify: Whit	te
20	72 ho	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most	t of working	16b. Kind of Business/Indu	stry
2	thin 7	nple	Elementary/Secondary (0-12) College (1	-4or 5+)	DO NOT use retired)			
2	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, ith "M-dreal Evaninan man be redified at	Completed	3 Year	cs Re	gistered Nurse		Medical	
ш	be fill stal H sd oth	Be	17. Father's Name (First, Middle, Last)			r's Name (First, Middle,		
yla	ould Mer narke	은	Charles Arthur Johnston			e Caroline		
Maryland 21215-0036	2 sh h and ris n	1	19a. Informant's Name/Relationship (Type. Print)	1	ng Address (Street and Number		•	
e, _	1 and Healt em 2		Melinda Timlen (daughte	<del></del>		Baltimore,	Maryland 212 20c. Location - City or Tow	
סר	nt of		1 ☐ Burial 2 X Cremation 3 ☐ Removal from	State	osition (Name of matory or other place)		•	
Baltimore,	it. Per intme injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Green Mou	int Crematory		Baltimore, Ma	aryrand
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Marcal Experiment to a profiled at once.		21. Signature of Purietal Service Eldersee	M	Name and Address of Facilit itchell-Wiedef 6500 York Road	eld Funeral	Home, Inc.	21212
		1 0	23a. Part 1. Per the lisease, or complications that of	aused the death. Do not en			rest	Approximate
	Dhysisian		shock, or heart failure. List only one cause on e Immediate Cause (Final	ach line.	incor No-			nterval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	(or as a conseque e of):	TIVEL DISC	40		
_	Examiner							
m.		je l	Sequentially list conditions, La place of the conditions, La place of the conditions, Cause (Disease or injury	or as a consequence of:				
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oʻ	e exe ian al ırial-t	Ä	resulting in death) Last Due to	(or as a consequence of):				
8760,	icate be executed physician and the burial-transit	dical	d					
9	ertific ling p e as t	Mec	IF FEMALE:			-347		
Вох	eath certific attending p	ian/	23b. Was decedent pregnant 1 Live		Ectopic pregnancy		23d. Date of delivery	y Day Year
0	requires that the death certifi veen signed by the attending I hould be detached for use as	by Physician/Me	1 ☐ Yes 2 ☑ No 4 ☐ Preg 9 ☐ Unknown 9 ☐ Unkr		Other (specify)			
σ.	ires that the de signed by the a be detached f	P.	Part II. Other significant conditions contributing to de	eath but not resulting in the u	inderlying cause given in Part I	. 23e. Did to	bacco use contribute to the	cause of death?
ds,	sign d be	d b				1 🗆 Y	res 2 □ No 3 □ Proba	bly 4 Unknown
50	> 1 8	Completed				24a. Was a	an 24b Were autops	sy findings available
Re	e lav has e 2	E D				autop	prior to com death?	pletion of cause of
a			25. Was case referred to medical		OC Diese	1 □Yes		? □ No
₹	Physician: this certific ral director,	Be c	examiner?	Inpatient 2 ☐ ER/Outpatie	Othori	e of Death (Check only o	dence 6 ☐ Other (Specify)	
of	a Phy er this eral o	12	27. Mann f Death 28a. Date	of Injury 28b. Time of			now injury occurred	
<u>o</u>	Attending r death. ector: After by the fune	랿	1 Natural 5 □ Pending (Mon 2 □ Accident investigation	th, Day, Year) Injury	M 1 Yes 2	No		
Division of Vital Records,	Atte	iji	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined build	of Injury - At home, farm, st ing, etc. (Specify)	reet, factory, office	28f. Location (S City or To w	Street and Number or Rural	Route Number,
Ö	s after al Dire	Certification: To	4 Carlomede Band	ing, old. (openly)		0.1, 0.1	, 0.0.0)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the					
	the H hin 24 the F mplete	Medical	one) CRNP and man	iner stated.				
	<b>5</b> vit	-	29b. Signature and title of certifier	1-1.0	29c. License number		29d. Date signed (Month, D	a, 1001)
	n .		January Ward	CALL	K15762	4	1/8/201	0
	JV		30. Name and address of person who completed cause JENNIFER HAUF, CRNP		, Print) E <i>Y VALLEY ROAD</i>	TIMONI	UM MD 21093	3
	Sta	te.		Registrar's Signature				
	Regist		1441 0 0 2010 A	A Last	9			

DHMH 17 Rev 1/2001

2010

JANUARY 8,

RIFFEE, MARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 2010<sup>a</sup> 12:45 AM CHARLES VINCENT ROLLER, SR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sparks Baltimore County 14410 Bonnie View Road If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number If Under 24 Hrs. 8. Date of Birth **Funeral** Sept 6, 1913 1 X M 2 □ F Months Days Hours Mary Land 96 Director 214-16-9583 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2X No Maryland Baltimore County Sparks 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21152 **USA** 14410 Bonnie View Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 38 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 M Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Painting Contractor Proprietor permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose B. Naylor Charles Roy Roller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Cynthia Zavorotny (Grandaughter) 14410 Bonnie View Road, Sparks, Maryland 21152 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Bosley U. Meth. Ch Cem1/9/2010 Sparks, Maryland 21. Signature Juneral Service L. Seed Mar t 1 D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME 6500 York Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial infarction Ph\_sician/ Day disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last the burialattending physician for use as the burial Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ The law requires that the death in the past 12 months? Month Dav Year 2 □ No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by within 24 hours after death.

To the Funeral Director: After this certificate has been signi completed filled in by the funeral director, page 2 should be 270 Dementia 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 🛛 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie Certifying Nume Practioner To the best of my knowledge, death press d at the time, date and place, and due to the cause(s) and matinion as state 29b. Signatore and title of certifier 29d. Date signed (Month, Day, Year) 1-5-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 54 Scott Adam Road, Jon Simon, MD, Suite #104, Cockeysville, Maryland 31. Date filed (*Month, Day, Year*) **JAN 0 8 2010** State Registrar

54:71010-2

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23>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20<sup>rear</sup>0 Jan 9:20 P<sup>M</sup> Dorcas Thomas Roggenkamp Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore County <u> Gilchrist Hospice</u> Towson Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Days 1 🗆 M 2 🖳 Hours (Month, Day, Year) Yrs. **Director** 053-18-9807 87 10.22 April Boston, MA Usual Residence of Decedent 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director 1 Yes 2 X No Lutherville-Timonium Maryland Baltimore Co.
10e. Street and Number 10g. Citizen of What Country? Funeral 21093 United States 12261 Roundwood Road unit 319 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimofe, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates is marked other than "natur aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Home Maker Own Home N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry Theodore Thomas Helen Sawyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 per it. Page 1 and 2 sh
Derartment of Health ar
Important if item 27 is
any injury or other trau 12251 Roundwood Rd. unit 701 Luth.-Tim., MD Mrs.Nancy R. Simms (Dau.) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Jan.08, 2010 4 Donation 5 Other (Specify) Evans Funeral Chagel Forest Hill, MD. Peaceful Alternatives Funeral&Cremation 2325 York Rd. Timonium, MD. 21093

se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Addroximate

Approximate 21. Signature of Funeral Service Licenses 23a. Part. Enter the dises Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ omplications of 1 N/5 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year as been signed by the 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy death? funeral director, page 2 No ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 💢 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suic 5 Pending Investigation after death the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R149194 January 6, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grant N. Charlis MD 101

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 2010 Physician/ Keddon 20:40 JAN Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** BALTIMORE Medical enter If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign irthday) 8 Date of Birth **Funeral** 1 1 M 2 □ F Yrs. ar Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Funeral Director 1 Yes 2 No Mar yland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? El Kader Rd. 3712 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? Black, White, etc.
Specify: Bac þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) abover Be 18. Mother's Name (First, Middle, Maiden Surname) ည Ivanel Jowers 20c. Location - City of Town, State 20b. Place of Disposition (Name of 20a. Metho of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Ap oximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus Immediate Cause (Final disease or condition ONE month Physician/ Medical resulting in death) Examiner ONE YEAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to totals a consequence of attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) ed by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed I page 2 should be det Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 
☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy To the Hospital or where within 24 hours after death.

To the Funeral Director: After this certificate has remoleted filled in by the funeral director, page 2 1 ☐ Yes 2 ☐ No Yes 2 **V** No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 🕅 No 1 Tes 1 Marient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 22071 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sancu A Sherr 10 North CH 10 NORTH Cheeve St BALTIMORE, MD 2,201 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

David Resse		S 1- For State Registrar	tate of Maryla		artment of rtificate of		Mental Hy		2 eg. No.	:010	0024
Physicia Medical Exami	an/	1. Decedent's Name (First, Mid						2. Date of Dea Month	Day	Year	3. Time of Death 1258 hrs
Nedical Exami	1161	David Joseph  4a. Facility Name (if not institut		mber)	1.	4b. City, Town, or Lo	ocation of Death	January 5		nty of Death	
		3608 Offutt Road				Randallstown				nore Cou	
Months						If Under 1 Year Months Days	If Under 24Hrs. Hours Min.		•	Foreign	hplace (State or
Director		Unk. 1 M 2 F 69 Yrs. World bays red by Usual Residence of Decedent					June .	L1, 194	40 Cor	intry)Maryland	
/ any		10a. State 10b. County	1	10c. City	, Town or Locati	on					10d. Inside City Limits
Maryland 28a-f show 1 at once.	ē		timore		Randa	illstown					1 Yes 2 X No
e Mary or 28a-	Director	10e. Street and Number	1			10f. Zip Code	2.2	1	0g. Citizen of		try?
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once.		3608 Offutt Ro		edent Ever in U		s Decedent of Hispa	anic Origin? ( Sp			SA lace - Americ	can Indian, Black,
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7 3 -	ed	<ol> <li>Decedent's Education (Sp Elementary/Secondary (0-12</li> </ol>				t's Usual Dccupatior ost of working life. D			16b. Killa ol	f Business/Ir	idustry
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	ပ္စို	17. Father's Name (First, Middle				18	.Mother's Name	(First, Middle, M nine Pop		ime)	
2121 ould be fi Mental marked	To Be	Thomas M. Rees  19a. Informant's Name/Relation			19b. Mailing	Address (Street a				Γown, State,	Zip Code)
O 5 5 5 5		Raymond D. Rec	ese, Brothe	er							, MD 21228
ore, ME es I and 2 s of Health au If item 27		20a. Method of Disposition  1 Burial 2 Crematic		om State	crematory or oth			Date	11-0	on - City or 1	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other 3	Specify:	Met		natory Ind		07/10			Maryland
Balti permit. Departr Import injury		21. Signature of Funeral Service	e Licensee Thoma	as Grego	or $\begin{bmatrix} 22 \\ 2 \end{bmatrix}$	ame and Address of Freder	Society ick Roac	Of Mary	land	Inc Marvla	and 21228
Physician		23a. Part I. Enter the disease, of failure. List only one caus		aused the death	. Do not enter th	ne mode of dying, su	uch as cardiac or	respiratory arre	est, shock, or	heart	Approximate Interval Between Onset and
Medicul Examiner		Immediate Cause (Final diseas	e a. Carbon Mo								Death
		or condition resulting in death)	Due to (or as a	consequence of	of):						
	Пēг	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		consequence o	of):						
.0 -	edical Examiner	(Disease or injury that initiated events resulting in death) Last	Durate (see as	consequence o	of):						
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be es		UNPENDED	AMENDED						T-01-0		
Ox 6876( ath certificate attending phys	M/W	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 1 Live b		2 Fe	tal death 3	Ectopic pregnar	псу	23d. Date Month	e of delivery h Da	ay Year
Box 6 death ce the attend	Physician/M		4 Pregn	ant at time of de	eath 5 Ott	ner (Specify)			1		
ion of Vital Records, P.O. Box 6876( tending Physician: The law requires that the death certificate teath. tor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the b		Part II. Other significant cond			esulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use co	ontribute to the	ne cause of death?
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of Vital Records, ng Physician: The law require ther this certificate has been si nneral director, page 2 should b	å	25. Was case referred to medic examiner?	Hospital:	npatient 2	ER/Outpatient	[]	f Death (Check o		Residence (	C D Othor	Cana
1 of Viding Physic	£.	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b. Time of Ir	•	at Work?	28d. Describe h	now injury occ	curred	
ion (tending eath. tor: A)	ţi		nding FOUND Jan 5, 2		FOUND: 1239 hrs	1 Yes	s 2 🗸 No	Subject exp	osed to to	xic fumes	
ivis or Al after of Direc	Certification:	3 Suicide 6 Co	ald not be 28e. Place	e of Injury - At h		et, factory, office buil		or Town, S	tate)		al Route Number, City
Divis		4 Homicide		Parking Lo				608 Offut Ro		_	
D To the Hospital within 24 hours To the Funeral completely filled	Medical		Physician: To the bes aminer: On the basis of and manner s	of examination a							
To witi	Me	29b. Signature and title of certif		tateu		29c. License n	number		29d. Date s.	igned (Mont	th, Day, Year)
		dhh bi	mell, MD	,		O.C.M.	.E.		January	6, 2010	
5		30. Name and address of person Melissa Brassell, MD				enn Street, Bal	timore, MD 2	21201			
	ate	31. Date filed (Month, Day, Year	W	gistrar's Signatu	ure						
Regist	_	JAN 0 8 2	UIU Steres	a d.	ORIGINAL						
J 1721		OCME			OKIOINA	<b>L</b>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 00243 State of Maryland / Department of Health and Mental Hygiene 2 [] Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 9:20 PM MAG 2010 SCHEIPS 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Silver Spring Renaissance Gardens If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, ) Feb. II, Year) 915 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Min. Hours Months Days 1 □ M 2 😾 F Illinois Yrs. 94 309-03-4976 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐Yes 2√ No Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20904 3116 Gracefield Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 🏋No Specify: Year or Dates: 3XXWidowed 4 ☐ Divorced 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Publishing Editorial Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arulla Parks Rita Co1e LeRoy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 414 Hungerford Dr. #215, Rockville, MD 20850 Maria Vacchio, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, MD 1/8/2010 Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Rapp Funeral and Cremation Services
Cook Cick Ave. Silver Spring, MD 20910 21. Signature of Funeral Service Licensee 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANEMIA Due to (or as a consequence of): GASTROINTESTINAL BLEEDING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 🗌 Ectopic pregnancy Year Month Day 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown YPOTHYROIDISM 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION 24a. Was an autopsy performed 2 □ No 2 No 1 Yes 1 ☐ Yes 26. Place of Death (Check only one) 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Death

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

show

Director

Funeral

2

Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ratural", or items 23a or 28a-f show important: If item 27 is marked other than "ratural", or items 23a or 28a-f show any injury or other traumatic event, I'm Moden Examina in ust be retified any injury or other traumatic event, I'm Moden Examina in ust be retified.

Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, the signed by t 1 be detach page 2 should certificate

Examine Physician/Medical director, funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

this

Hospitai

2

Completed

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Certification: To

Medical

State

Registrar

23b. Was decedent pregnant in the past 12 months? ☐Yes 2 No g ∏ Unknown

25. Was case referred to medical examiner? 1 Yes 2 No

5 Pending investigation

6 Could not be determined

Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Natural

2 Accident

3 Suicide 4 \ Homicide

> 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
>
> 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier Coman,

2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 0 8 2010

KORZAN

3160 GRACEFIELD RD SILVER SPRING MD MD 32. Fegistrar's Signature

MP

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 0 | 0 State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate	e of Death	Reg. I	No.		
Physician/ 1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month Day, Year							
ledical Exami	ner	Anna M. Stickel		January 5, 20	010 0916 hrs		
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	h	4c. County of Death		
		Old Orems Rd south of Middle River Road	Middle River		Baltimore County		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24Hr	s. 8. Date of Birth(N	MM/DD/YYYY) 9. Birthplace (State or		
Director		$212-45-2444 \mid_{1 \mid_{M}} 2 _{X_{F}} \mid 14$	Yrs. Months Days Hours Mi	June 6,	, 1995 Country MD		
	ŀ	Usual Residence of Decedent		<u> </u>			
á	ŀ	10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits		
- F 00 4	.	MD Baltimore Mid	dle River		1 Yes 2 No		
Maryland 28a-f show any datonce.	횴	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?		
ne Maryland or 28a-f sho fred at once.	Director	764 Maple Crest Drive	21220		USA		
th the 23a o notifi			NAME Description of Discription (1977)	Sanaife Was as No.	14. Race - American Indian, Black,		
th wi	Funeral	1 X Never Married 2 Married Armed Forces?	<ul> <li>Was Decedent of Hispanic Origin? ( § If Yes, specify Cuban, Mexican, Puert</li> </ul>		White, etc.		
or dea	ᆵ	1 Yes 2 No	Yes 2 No specify:		Specify: White		
s after	۵	or Dates:	edent's Usual Occupation (Give kind of	work done 16	ib, Kind of Business/Industry		
hour "nate	te q	Elementary/Secondary (0-12) College (1-4 or 5+)	ng most of working life. DO NOT use re		·		
5-0036 led within 72 hou Hygiene. tother than "nat	omplete	9th St	udent		School		
1 with	ē	17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, Maid	den Surname)		
215-0036 be filed within 7 nal Hygiene. ked other than	Be C	Michael A. Stickel Sr.		. Walter			
212 ould be Ment mark	0		ailing Address (Street and Number or				
MD and 2 shot alth and m 27 is aumatic		Tara Leigh Stickel /mother 7	64 Maple Crest	Drive Ba	altimore MD 21220		
and and tealth tem	ŀ	20a. Method of Disposition 20b. Place of D	sposition (Name of cemetery,	Date 20	Oc. Location - City or Town, State		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shinjury or other traumatic event, the Medical Examiner must be notified at once		1 Surial 2 Cremation 3 Removal from State crematory	or other place) Hill Cemetery 1	/9/10	Baltimore Mp		
timen trant	ļ	4   Donation 5   Other Specify:					
Balti permit. Departi Importi injury	.	21. Signature / Fyneral January nisee	22. Name and Address of Facility 3 (				
		23a. Part   Enter the disease, or complications that caused the death. Do not e	Connelly Fune:	or respiratory arrest.	of Essex 21221 shock, or heart Approximate Interval		
Physician		failure. List only one cause on each line.	nor the mede of dying, each de eardide	o, 100pa.o.,	Between Onset and Death		
Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			Death		
		or condition resulting in death)  Due to (or as a consequence of):					
	ᡖ	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):					
	盲	cause. Enter Underlying Cause					
. g	Examine	events resulting in death) Last  Due to (or as a consequence of):					
ecute and trans		d.					
3760, ficate be executed g physician and street transit	edical	UNPENDED					
Box 68760, e death certificate be the attending physic ed for use as the bur	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	·		23d. Date of delivery		
68° certifi ding	jan	past 12 months?	7	nancy	Month Day Year		
Box 687  The death certifice the attending part of the ast of the	sic	1 Yes 2 No 9 V Unknown 9 Unknown	Other (Specify)				
the d	Physician/M	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?		
P.O.	þ			1 Yes	2 ✓ No 3 Probably 4 Unknown		
<b>S,</b> quire en sig	ted			24a. Was an	24b. Were autopsy findings available		
Orc aw re as be 2 shor	음			autopsy performe	prior to completion of cause of		
Rec The la	Completed			1 ✓ Yes 2			
Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should!	Bec	25. Was case referred to medical	26.Place of Death (Chec	( only one)			
Vita nysici this c		examiner?  1 V Yes 2 No  Hospital: 1 Inpatient 2 ER/Outp	atient 3 DOA Other Nurs	ing Home 5 Res	sidence 6 Other: Scene		
Of ng Pt Mfter uneral	اءًا	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tim	e of Injury 28c. Injury at Work?	28d. Describe how	injury occurred trian struck by train		
On endiversity or: /	lii	1 Natural 5 Pending Jan 5, 2010 (Month Qay Year) 0905 h	S 1 Yes 2 ✓ No	Oubject pedes	man struck by train		
/iSi or Att iter de in by	Ę	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	street, factory, office building, etc.	28f. Location (Stre or Town, State	et and Number or Rural Route Number, City		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certil within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification:	4 Homicide determined (Specify) Other (railway trace	ks)	Old Orems Rd so	outh of Middle River Rd, Middle River,		
Hosp 24 ho Fune tely f		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, ar	id due to the cause(s	) and manner as stated.		
thin ithin or the	edical	one) 2 Medical Examiner: On the basis of examination and/or inve	stigation, in my opinion, death occurred	at the time, date and	I place, and due to the cause(s)		
_ E3E8	Me	29b. Signature and title of certifier	29c. License number	29	9d Date signed (Month, Day, Year)		
		Mh k all M	O.C.M.E.	J	lanuary 6, 2010		
6.1		30. Name and address of person who completed cause of death (Item 23a)					
JV		Melissa Brassell, MD Assistant Medical Examiner 1	11 Penn Street, Baltimore, MI	21201			
S	tate	31. Date filed (Month Day Year) 8 2010 32. Restrar's Signature		-			
Regis	trar	JAN U 8 2010 Cener A	barre				
DHMH 17 Rev 1/2		ORIG	INAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2010 Smith C. Tyrone January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greneral LOSPITAL naryland If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□ F 55 10/31/1954 Maryland Director <u>217-62-</u>8598 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy figury or other traumatic event, the Modest Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 1 XYes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 U.S.A. 4306 Seminole Avenue Apt 202 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No 14. Race - American Indian. Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Specify þ 3 Widowed 4 Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Job Housing Elementary/Secondary (0-12) College (1-4or 5+) Grade Supervisor Recovery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Council Annie Houston Johnnie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Michae</u>l Randolph (Nephew) 1104 N. Parrish St., Balto., MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 01/13/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cem. <sup>22</sup> Name and Address of Eacility Joseph H. Brown Jr. Funeral Home 21. Signature of Funeral Service Licenses 2140 N. Fulton Ave., Balto., MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hemoptysis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed to the death certificate be executed. the attending physician and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown been signed by the should be detach Part II.,Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this filled in by the funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 1 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a fix Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal To the i and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Iter

Print)

Amend 24a-b, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 11:25 PM osalee Spencer 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltinger 1 If Under 24 Hrs. NIA Mercy 1 5. Social Security Number Mexical inter 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign South Carolin last birthday) Funeral 218-26-1□M 2**X**F Months Days Hours Min. 6444 Carolina Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show in than "natural", or items 23a or 28a-f show Des 2 No 010 Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 120 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. A 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 Baltimore, Maryland 21215-0036 Completed by Specify Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other thar 12+6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ 19a. Anformant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trains once. Wan 20b. Place of Disposition (Name of cemetery, crematory ar other place) 20a. Method of Disposition Date Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) 22. Name and Address of Faulity ture of Funeral Service Licensee 2/22 23a. Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or nearly ailure. List only one cause on each line. Immediate Cause I final disease or condition resulting in death) Approximate Interval Between Onset and Death **Physician** hrs /Medical Examiner Ventriculus Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Fracture Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) cate has been signed by the page 2 should be detached it 1 Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Atelectos, 24a. Was an COPD certificate 2X No 25. Was case referred to medical examiner?
1 ☐ res 2 ☐ No director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 2 Accident -28-2009 0845 M Pall 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Home 124 W. Franklim Street, Baltumore 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ASSECIAL DOO 26956 116/16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Place Bultimore MO St 301 M.O. 32. Registra is Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 Month Glenn F. Schafer М 11:25P Medical Januarv 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) Funeral Hours 1 X M 2 □ F Yrs. Director 217-46-0309 January Marvland or 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Mdx. Harford Forest Hill 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1941 Pleasantville Rd. 21050 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 

Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 X Married Š Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Specify: White Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me gines. Elementary/Seconday (0-12) College (1-4 or 5+) Owner Plumbing Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John A. Schafer Ruth Ament 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie L. Schafer Spouse 1941 Pleasantville Rd. Forest Hill, Md. 21050 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview 1-8-2010 Balto. Md. 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySchimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ CCO disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** ono Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year 1 ☐ Yes ∠ ☐ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N this certificate Yes 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending Accident

Suicide

Homicide 1 Yes 2 No Investigation 24 hours after deat Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and tipe of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES 31. Date filed (Month, Day, Year) 32. Regist State Registrar

DHMH 17 Rev 7/2009

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month Olay 2010 **Physician** 8:00 Ам January Josephine E. Schuler /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Stella Maris Nursing Home Timenium If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Hours Min. Days 1 □ M 2 🛛 F 92 Yrs. Maryland 217-07-5252 March 19, Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is a filed. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Nottingham Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21236 U.S.A. 9469 Seven Courts Drive Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No 21215-0036 If Yes, Give Year or Dates: Specify. White Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Jos A Bank Seamstress 18. Mother's Name (First, Middle, Maiden Surname) UNK 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Maryanna Anthony Anello ပ္ 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9469 Seven Courts Drive, Nottingham, MD 21236 19a. Informant's Name/Relationship (Type. Print) Mary Sutton-daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Evans Funeral Chapel Bel Air 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 01/06/2010 Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 21. Signature of Funeral Service Licenses n1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nock, or heart failure. List only one cause on each fine Approximate Interval Between Onset and Death Impactiate Cause (Final lease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown for use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ot s after death.

I Director: After this id in by the funeral d 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier LESink 100 JANUARY 4, 2010

Registrar

State

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JANUARY

SCHULER

JOSEPHINE

23QQ DULANEY VALLEY ROAD

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDDIE NAKHUDA,

2010 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 06 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ste none Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, 1 🗆 M 2 🗙 F Months Days Min. **Director** 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director H.11 1 🗆 Yes 2 📉 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1  $\square$  Never Married 2  $\square$  Married 1 Yes 1 Yes 2 No White Specify. Specify: 3 Widowed 4 □ Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene nome JUME wake Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 11, mo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Hsville Forest HI Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 21. Signature of Funeral Service Licent 22. Name and Address of Facility Fryneral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition BREAST CANCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or impury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical tor: After this certificate has been signed by the attending k the funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 🗶 No Day Year 4 Pregnant at time of death 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1  $\square$  Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Division of Vital Hospital Other: 2 **X** No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending 2 No 2 Accident
3 Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 🗀 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

X Cortliving Nurse Practioner To the basis of my knowledge, death continued at the film, date and place, and the cause(s) and manner as stated. 29b. Signature an 29d. Date signed (Month, Day, Year) 29c. License number 2010

Registrar
DHMH 17 Rev 7/2009

State

61

90:9

JANUARY

2300 OULANEY VALLEY RD.

of person who completed cause of death (Item 23a) (Type, Print)

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **2010**Year **Physician** Dorothy Smoot <del>2009</del> 5:20 p M January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Somerford Assisted Living Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 18 Birthplace (State or Foreign Country) 5**29031 S8011124178** 216-05-3463 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 💆 F Hours 96 Jan. 1913 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 1 ☐ Yes 2 No Director Maryland Baltimore Reisterstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21136 Road United States 118 Danbury Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after 1 ☐Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify. White Specify: ð 3 Widowed 4 □ Divorced Completed 16h, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education alth and Mental Hygier 27 is marked other the traumatic event. Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Reuben Bair Lillian Smith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Janice Cline / Daughter 118 Danbury Road, Reisterstown, Maryland 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 6. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2010 Baltimore, Maryland <u>Metro Crematory,Inc.</u> 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 4 years Alzheimer's Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) □Yes 2□No Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has be rector, page 2 s autopsy perform 1 ☐Yes 2 🛛 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Ving Hospital: 1 Yes 2 No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral C
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D56531 January 6, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li, M.D. 8600 Snowden River Parkway #301, Columbia, Maryland 21045 31. Date filed (Month, Day, Year) 32. Egistrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #2, per DVR g899 1.8/10 TT/ #5perFH, 8899, 1/19/2010, WS

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

**JAN 0 8** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Silverstein Physician/ anle 08:32A Jan 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12012 OLD FREDERICK ROAD MARRIOTTSVILLE HOWARD Birthplace (State or Foreign Country)
 MD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Funeral 1 X M 2 - F 107271918 Director 212-05-9910 91 MD Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🕅 No MARRIOTTSVILLE MD HOWARD 10e. Street and Number 10g. Citizen of What Country? Funeral 12012 OLD FREDERICK ROAD 21104 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify 3 X Widowed 4 ☐ Divorced WHITE Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) OWNER LUMBER COMPANY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev **JACOB** SILVERSTEIN CARRIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLENE TOWNSEND / DAUGHTER 12012 OLD FREDERICK ROAD, MARRIOTTSVILLE, MD 21104 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Special DRUID RIDGE CEMETERY 1/7/2010 PIKESVILLE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, 21. Signatur of Funeral Service Li , INC MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Dneumonia Physician days disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of, Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death the a Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an **Director:** After this certificate has I in by the funeral director, page 2 s autopsy perform death? 2 No Yes 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 2 No |2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide after death. Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifing Nurse Practioner; Tonge best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 Certif within 2 29b. Signature and title of

State

Registrar DHMH 17 Rev 7/2009 Scott

2465

person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D29909

Jan. 6, 2010

Rt 97 Ste10 Glenwood, Md 21738

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

00252

			1 - State Registrar Ce	ertificate of Death	Reg.	No. ZUIU UUZJZ		
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death		
	Physici /Medic		ROSE SLOVSKY		5, 2010 9:57AM			
- and	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death  4c. County of Death				
ne sur			GENESIS NURSING HOME	SEVERNA PARK		ANNE ARUNDEI		
	Funeral		<ol> <li>Social Security Number</li> <li>Sex</li> <li>Age (In yrs. last birthday</li> </ol>	) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yes 05/25/192	9. Birthplace (State or Foreign Country)		
	Director		216-14-7046 1 M 2 T F 87 Yrs.		05/25/192	22 MD		
	pu ,		Usual Residence of Decedent	ti		10d. Inside City Limits		
	larylan show	'n	10a. State 10b. County 10c. City, Town or L			1 ☐ Yes 2 ☐ No		
	Ba-f	cto		TIMORE				
	or 2	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?		
	ath w	ral	156 WEST BARRE STREET	21201		USA		
	er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - American Indian, Black, White, etc.		
36	s aft	by F	1 □ Never Married 2 □ Married 1 □ Yes 2√□ No If Yes, Give 1 Year or Dates:	1 ☐ Yes 為XXNo Specify:		Specify: WHITE		
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dreal Exp. in or must be notified at	ed		edent's Usual Occupation	16b	. Kind of Business/Industry		
15	in 72 n "na Ledic	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of work DO NOT use retired)		,		
7	filed within Hygiene. Ither than '	шо	Elementary/Secondary (0-12) College (1-4or 5+)	OFFICE MANAGER	PR	ROMOTION-TOURISM		
D	illed Hygi other ent, th	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maid	den Surname)		
a	should be I and Mental marked o umatic eve	To B	BENJAMIN WISE	DORA		UNKNOWN		
ary	shou and N s mar	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ling Address (Street and Number or Ru	ral Route Number, Ci	ty or Town, State, Zip Code)		
Š	od 2		BARRY SLOVSKY-SON 156 W	VEST BARRE STREET,	BALTIMORE,	MD 21201		
ē,	ges 1 ar it of Hea if item or other		20a. Method of Disposition 20b. Place of Disposition	position (Name of ematory or other place)	Date 20c	Location - City or Town, State		
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Baltimore, Maryland	permit. Pag Department Important: I any injury o			22. Name and Address of FacilitySOL				
ä	permi Depar Impor any ir			3900 REISTERSTOWN				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between		
Janes .	Physician			ROTIC CARDIOVA				
	/Medical		resulting in death)  Due to (or as a consequence of):	ROTTE CHESTOTI	JUL WIL	DIVERSE YES		
-	Examiner							
	D +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
	scuted nd ransit	Examiner	that initiated events C.					
0,	be execut sician and burial-tran		resulting in death) Last Due to (or as a consequence of):					
68760,	ate the	/Medical	d					
	certific nding p	Mec	IF FEMALE:					
Вох				Ectopic pregnancy		23d. Date of delivery  Month Day Year		
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σ.	that the denoted by the detached	Ph)	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did tobac	co use contribute to the cause of death?		
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3ec	e law has l	du			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?		
a	ian: The l rtificate ha				1 □Yes 2 🖻			
V.	Physician: r this certific ral director, I	Be	25. Was case referred to medical examiner?  Hospital:	0.1	th (Check only one)			
of	Phys this	2	1 Inpatient 2 ER/Outpati	ent 3 DOA 4 Nursing H		e 6 Other (Specify)		
	ding Pt n. After tt funeral	ion	1 Natural 5 Pending (Month, Day, Year) Injury	of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how i	njury occurred		
isi	Attending or death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be determined		28f Location (Stree	at and Number or Rural Route Number,		
Division	or A after Direct in by	Certification:	4 Homicide determined building, etc. (Specify)	troot, tablory, office	City or Town, S	tate)		
	Hospital 24 hours a Funeral 1 itely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place	e, and due to the caus	se(s) and manner as stated.		
	24 h 24 h e Fur letely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.					
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature applittle of certifier	29c. License number	29d.	Date signed (Month, Day, Year)		
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	3 V		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)				
	2 0		BRIAN C. WALLACE, UND 900	OS KICBRIDE	RD., 15%	27/mare, mi) 21226		
	Sta		31. Date filed (Month, Day, Year) 32. Restrar's Signature	7	7	,		
	Registr	ar	TENTOS 2010 R	Banks !				

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #10e Per FH 6899 1/08/09 JB/ #10e perFH 6899 1/11/2010 WS
State of Maryland / Department of Health and Mental Hygiene 00253 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year A Tan 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner altimare If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 04-23-1917 5. Social Security Numbe Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2**X**) F Months 215-09-8073 92 Director MD Usual Residence of Decedent 23a or 28a-f show within 72 hours after death with the Maryland an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Linthicum MD 1 Yes 2 XNo 134 Oreet and Number 10f. Zip Code 21090 10g. Citizen of What Country? Funeral 810 Chestnut Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2XX Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian H. Garrett ည Melvin B. Gorrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 32/p Code) 13912 Glen High Road, Baldwin, MD 21013 Walter Tydings / Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Mem. Park 01-13-2010 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State injury or Elkridge, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility
Bailey Funeral Home and Cremation Service, PA
4023 Annapolis Road, Halethorpe, MD 21227 any mal Ei MO145 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Enysician/ ACUTT MYOTARA disease or condition Medical resulting in death) Examiner AThecastleso Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE yes, outcome of pregnancy □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death ate has been signed by the a page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed's death? certificate 2  $\square$  No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 22No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this the funeral 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No Natural injury 5 Pending within 24 hours after death. To the Funeral Director: A М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) UNAZICIT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 21225 Michael Jiverna Saim HANDUEL STIET Boltware 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Erica Felice Wen January 03 2010 D Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months May 7 1946 Days Min. 1 □ M 2 😾 F 63 330-38-4147 China Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20910 United States 704 Woodside Pkwy. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Asian Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Painting Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frank Ling Harriett permit. Page 1 and 2 should be 1 Department of Health and Mente Important: If item 27 is marked any injury or other traumatic en 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 704 Woodside Pkwy., Silver Spring, MD Eddie Chang / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 D Removal from State Chesapeake Crematory 1/05/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service bice M00382 Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Colon CA Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Severe Malnutrition Sequentially list conditions Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit Colonic Obstruction The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2XXNo Day Year Month Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the sempleted filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4XXUnknown Records, Emphezema 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy performe 1 Yes 2 No Yes 2 X No Hospital or Attending Physician: 26. Place of Death (Check only one) **Division of Vital** Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2XXN0 1 X Inpatient 2 ER/Outpatient 3 DOA မှ 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) XNatural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Fertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D65312 3 30. Name/and/address of person who completed cause of death (Item 23a) (Type, Print) 10 20814 8600 Old Georgetown Rd., Bethesda, MD Sudarshan Siva, M.D.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN 08 2010

Death: 13:25 pm

40

. Registrar's Signa

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Kimberly Willhoit		#8 1- For State Registrar	K Sta	te of Maryla			ment of ficate of		nd N	Mental F		Reg. No.	20	1		125
Physician	1/	1. Decedent's Name (Firs									Date of De    Month	ath Day	Year	1	3. Time of De	
Medical Examin		Kimber  4a. Facility Name (if not in		Lynn give street and nu	Willi	noi		lb. City. Town,	or Loca	ation of Dea	January	4, 2010	County of	Death	0559 hr	·S
		Franklin Square		•				Rosedale					altimore		nty	
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any —	-	Usual Residence of Dece 10a. State 10b. 0			10c.	City, To	wn or Location	on							10d. Inside C	City Limits
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15-003( filed within al Hygiene. ed other tha	Completed	17. Father's Name (First, I	fiddle, L	ast)					18.M	fother's Nam	e (First, Middle	Maiden				
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Baltimore, ME permit. Pages I and 2 s Department of Health at Important: If item 27 Important: other traum	t	21 Signature of Funeral S			4014		22. Na	ame and Addre	ss of F	acilitCAF	'A/Ster	hen	D	[.oł	rmanı	n PA
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Physician Medical		failure. List only one	cause or	each line.					g, 500i	r do caraldo	or roopiratory a	7001, 0110	or, or riour		Between O	nset and
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68760 certificate l nding physise as the bu	Σľ	IF FEMALE: 23b. Was decedent pregna	nt in the	23c. If yes, o	outcome of p	regnan	су	al death 3		ctopic pregn			l. Date of de Month	livery D:	av N	Year
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Division of Vital Records, P.O. Box 6876 rat or Attending Physician: The law requires that the death certificate rate death.  "I Director: After this certificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the least the control of the control	6	. arti. Othor olgimicant	onomo	io contributing to	death bath	10116341	ang in the di	idenying cause	giveri	iiir ait j.					ibly 4 🗹 U	
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F		Donna M. Vincen		Assistant M	ledical Ex		er 111	Penn Stree	t, Bal	Itimore, N	1D 21201					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #8. 19b per FD G899 1/19/2010 TT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 1625M 6 Jan Patricia Gale Washington 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1944 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** New Jersey Hours 1 □ M 2 🗓 F 0471571949 Director 577-58-9951 65 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Silver Spring MD Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 U.S.A. 2948 Hewitt Avenue, Apt. 357 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 Black 1 Yes 2 X No Specify Specify: 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Docket Clerk Federal Government 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Murphy Eugene Bentley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 14000 Castle Blvd. Benjamin Bentley/Son Apt 102 Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Ardent Cremation Services 01/08/2010 1 Burial 2 X Cremation 3 Removal from State Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, o emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final encephalopath enysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Uremio Sequentially list conditions, Examine it any leading to in mediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Renal failure To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death g ☐ Unknown 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical | a 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Tes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Jan 6, 20 (0 AT24380146 anh Olmo. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boltimuse, Mo Union Memorial Hospital loung MD 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #9 per FH G899 1/8/10 TT amend item 5 per fh g899 1-27-10 vt

For For State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Yvonne Walker , 2010 5 JANULOU /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Beltimore

Min. 57. A swest 5. Social Security Number 066-76-34 Hospital Birthplace (State or Foreign Country) Grenadines 7. Age (In yrs. last birthday) **Funeral** Year) 1 □ M 2 1 F Days Yrs. Vincent Island Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Eventher must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Catonsville MD Baltimore 1 ☐ Yes 2 ☐ No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21228 204 Winters Lane Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 27 No Specify: specify: African-American þ 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dynamic Health Memt 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Linda Shoy Ralph Frederick ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5402 Padecke Avenue Baltimore, Maryland 21206 Karen Walker / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/ 12/ 2010 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge 22. Name and Address of Facility Wylie Funeral Lomes P.A. of Balto. Co. 21. Signature o Funeral Service Licens 9200 Liberty Road Randallstown, Maryland 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Ventriblar Fibrillahon 25 minutes /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 255 No Month Dav Year 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an certificate has b irector, page 2 sł autopsy performed? Yes 220No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No ≥ ER/Outpatient 3 DOA 1 Inpatient this Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural

Accident 5 | Pending within 24 hours after death.

To the Funeral Director: Accompletely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 721325 7 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave Baltimoré no Height JACOBS 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Williams 2010 Edna Ryan Jan. 5:35a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Genesis Eldercare-Severna Park Severna Park Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Unit, Birthplace (State or Foreign Country) 5 Social Security Number 6 Sex 7. Age (In vrs. last birthday) Funeral York 1 □ M 2 🔯 F 1930 Director 119-24-6184 New Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Inc. Modical Evanings in ust by nothing at 1 ☐ Yes 21 No Director Maryland Anne Arunde1 Severna\_Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 344 Fairtree Plaza Ext. 21146 Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 72 hours after 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ₩ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any Injury or other traumatic event, Iranna Elementary/Secondary (0-12) College (1-4or 5+) Legislative Assistant State Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew Thomas Ryan Pauline Volk ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald J. Williams/ Husband 344 Fairtree Plaza Ext, Severna Park, Maryland 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 5. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 Metro Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of FacilitCremation Society of Maryland, Inc. Juneral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LLOVE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical attending plant for use as as IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 10 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy certificate 1 □Yes 2 □No 1 ☐Yes 2 ☐ No director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 1 ☐ Yes 2 ☐ ☐ O 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) this Medical Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Accident 124 hours after death.

Be Funeral Director: A pletely filled in by the function 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 29a. Certifier 🗫 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. \*\*Partifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npletely i (Check only one) within 2.

To the F
complete 29b. Signature and title rtifier 29c. License number 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nancy Regina Yelton Month Day 11:30A. M 6.2010 Medical January 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9915 Gunforge Road Perry Hall <u>Baltimore</u> Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, 1 □ M 2 🗑 F Days 42 Yrs. Director 220-88-3561 lune 16, 1967 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Harford Md. Baldwin 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2704 Hunting Ridge Court 21013 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: White 3 Widowed 4 Divorced Specify: Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Pharmaceutical Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Russell F. Covahey Anne L. Chrest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Sherwood Yelton Spouse 2704 Hunting Ridge Court Baldwin, Md. 21013 20a. Method of Disposition
1 

Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite 4 Donation 5 Other (Specify) 1-9-2010 Highview Memorial Fallston, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral HomeShummen Coognove 9705 Belair Rd. Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) MO Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examir that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 XNo
9 Unknown jo Month Day Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, Completed 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 X No To the Hospital or Attending Physician: To Be **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence of Other (Specify) Mother funeral ( 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 Tes 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

CM.D

32. Registraris Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Zaworski Januar Raymond Medical 4a. Facility Name (if pot institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** November 9, 1931 1 X M 2 □ F Months 78 Maryland Director 217-01-3051 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director or 28a-f Baltimore Nottingham 1 Yes 2 Xi Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 21236 USA 27 Stone Park Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc β 1 X Never Married 2 Married 1 Yes 2 XNo Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) N/A 6 years Never Worked Be Itimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Niziolek Michael Zaworski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail M. Posluszny niece 27 Stone Park Place, Nottingham, Maryland 21236 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) January 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory 4 Donation 5 Other (Specify) 2010 Signature of Funeral Service Licensee Name and Address of Facility of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease or complications that caused the death. Do figt enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-trans Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached for 9 Unknown P.O. To the Hospital or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ Impatient 2 Impatient 3 Important 2 Import this funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 5  $\square$  Pending Matural work? 1 🗌 Yes 2 🗆 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, (Check Certifying Nurse Prantioner: To the best of my knowledge d at the time, date and place, and due to th 29b. Signature and title of certifler 40059540 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven Boulevard, Baltimore 1eveson 5601 31. Date filed (Month, Day, Year) Registrar DHMH 17 Rev 7/2009

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	ysicia Medic		Ronald	Paul	Bu	ıllock	5				Januar	y 9	2010 Year		16:50 P M
	xamin		4a. Facility Name (if not institution,					4b. City,		ocation of Death			c. County of Dea		
. *			33 Stemmers Run 5. Social Security Number	er Ro		ae /la ure la	ast birthday)	If Under	Essex	f Under 24 Hrs.	8. Date of Bir		Baltimor		
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death	mer m		11. Marital Status	Ar	as Decedent		6. 13. V	Vas Deced	ent of Hispa	anic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit		
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<b>Saltimore,</b> Dermit. Page 1 and Department of Hea	injury	1	4 ☐ Donation 5 ☐ Other (Sp. 21. Sign for e of Funeral Service Lice		0	Oak	Lawn		ery d Address of	1/12/			ltimore, Funeral		
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x 08 h certific tending	r use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If y	yes, outcom	e of pregnal	ncy I death 3	Ectopic p	regnancy				23d. Date of de		
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that th	detac	۲ ا	Part II. Other significant condition		7		ulting in the u	nderlying c	ause given	in Part I.	23e. Did to	obacco	use contribute to	the c	ause of death?
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e law requires has been sig	2 sho	nple									24a. Was auto	DSV	prior to	itopsy compl	findings available etion of cause of
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G Phy G Phy Ter this	neral		27. Manner of Death		a. Date of inj (Month, D	urv	28b. Time of injury		c. Injury at		28d. Describe l		6 Other (Spec ry occurred	спу)	
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DIVISION (a) or Attendin (b) after death.	in by	Certificate:	4 Homicide determin		e. Place of In building, e	jury - At ho tc. (S <i>p</i> ec <i>ify</i> )	me, farm, stre	et, factory,	office		28f. Location (\$ City or Tow		nd Number or Ru e)	ral Ro	ute Number,
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending parts.	od filled	Medical	29a. Certifier 1 Certifying I	hysician: 1	To the best o	f my knowl	edge, death o	ccured at t	he time, da	ate and place, an	d due to the ca	use(s) a	nd manner as sta	ated.	
the H	прlеtе		only one) 3 L Certifying I	aminer: On Nurse Prac	the basis of tioner: To the	examination e best of my	knowledge, d	eath occurr	ed at the tir	me, date and plac	the time, date a e, and due to th	e cause	s) and manner as	stated	
ნ. <u>≱</u> ნ	8		29b. Signature and title of certifier	latin	1.11	m	1_		License nu			29d. Da	ate signed (Manti		<i>'</i>
			30. Name and address of person w	ho complete	ed cause of	death (Item	23a) (Type, P			1			111/2	01	0
			9103 Franklin	13014	iare	Dri	of Ste	. 200	2 oc	altimo	16 M	Da	1237		
Re	Stat gistra	e Ir	31. Date filed (Month, Day, Year)		32. Regist	rar's Signat	ure de				•				
				7-9		77.	CAN SELLEN								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ALERIE 15.59M IRGESS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MARYLAND. SOUTHERN LINTON MD CHARLES 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Min 1 🗆 M 2 💢 F Hours wash. DC Director show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director WASH. DX WASH. 1 XYes 2 ☐ No 10e. Street and Number r must be r 10g. Citizen of What Country? Funeral E. CAPITOL ST. NE#102 20019 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Yes 2 XNo Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည George T. Smith Margaret Jackson 19a. Informant's Name/Relationship (Type, Print)
|Ronald Burgess/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4256 E. Capitol St. NE #102 Wash. DC Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Lincoln Cem. Ft. 1-15-09 Brentwood, MD 5 mature of Funeral Service Licen 22. Name and Address of Facility Ronald Taylor Honald 10583 Middleport Ln. White Plains, MD 206%5 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RTERY ORONAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events IABET Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? hin 24 hours after death.

the Funeral Director: After this certificate 1 Yes 2 No Y Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner: 2 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Li Medical Examiner: On the basis of examination and/or investigation, in my opinion, deam occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 315 2010 anno 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR.#103, CLINTON, MD FRANCIS D. DICKSON 31. Date filed (Month, Day, Year) State JAN 1 1 2010 Registrar

Registrar
DHMH 17 Rev 1/2001

State

Bal

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

EISENSTOO

31. Date filed (Month, Day, Year)

State Registrar

OCME

Assistant Medical Examiner

32. Registrar's Sigg

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD

**ORIGINAL** 

111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCMF 2006

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 0265 State of Maryland / Department of Health and Mental Hygiene

		1- For State C6 Registrar	ertificate of Death	Reg. No.	
Physici	an/	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
/ledical Exam	iner	Lean Cauthorne		Month Day Year January 6, 2010	0000 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	h 4c. County of Death	
3		Bon Secours Hospital	Baltimore	NA	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday) If Under 1 Year If Under 24Hr:  Months Days Hours Mir	s. 8. Date of Birth(MM/DD/YYYY) 9. Birth	nplace (State or number)
		Usual Residence of Decedent		1	
v any			y, Town or Location		10d, Inside City Limits
and shov	ō	Md   MA   E	paltimore		1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Coun	try?
th the Maryland 23a or 28a-f sho notified at once.		1824 n. Fulton Ava	21216	CL.S. A.	V
n with ms 2.	uneral	11. Marital Status 12. Was Decedent Ever in U	J.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Display Rican, etc.)  14. Race - American White, etc.	an Indian, Black,
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Montal Hygener 77 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once	Fun	1 Yes 2 No		Dia	- 4
s afte ral",	by	3 Widowed 4 Divorced of Yes, Give Year or Dates:	1 Yes 2 No specify:	9,550,151	
hour natu	pe	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		idustry
36 hin 72 e. than '	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	Roofer	D C.	
5-0036 iled within 7 Hygiene. I other than	mo:	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)	
215 e filec al Hy ced ol	Se C	4.13	P (	Cauthorn	4
2121 vuld be fii Mental II marked	To B	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number or	Rural Route Number, City or Town, State,	Zip Code)
MD d 2 sho lith and n 27 is sumati		Sheritta Murriax Lauchter	13316 Cliftmont An	4. Balto, Hd. 212	13
C 4 # 77		20a. Method of Disposition 20b.	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or 1	Γown, State
MOF Pages ent of nt: If	l (i	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:		5-2010 Bulto.	lil.
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Specify:  21. Signature of Funeral Service License	Name and Address of Fall y	Les Eunival Serv	PA.
Deg E	en 98	Carlon C. Dandan	1701 McC. Wah	St. 75alfo. Md. 2	1217
Physician		23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.	n. Do not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	0. 9		atherosclerotic cardiov	ascular disease	Death
Lxammer		or condition resulting in death)  Due to (or as a consequence	of):		
	er	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of the consequenc	of).		
	i i	cause. Enter Underlying Cause (Disease or injury that initiated			
ed sit	Examin	events resulting in death) Last Due to (or as a consequence	of):		
760, icate be executed physician and the burial - transit		UNPENDED X AMENDED			
760, Trate be ex g physician the burial	Medical	23a,PII,	27,permE, g899 1/29/10	TT 23d. Date of delivery	
		IF FEMALE: 23b. Was decedent pregnant in the  23c. If yes, outcome of pregnant in the	gnancy  2 Fetal death 3 Ectopic pregna		ay Year
Box 68's death certificate attending	Physician	past 12 months?  4 Pregnant at time of d			
Bo; e deatl the att	hys	Yes 2 No 9 Unknown 9 Unknown			
, P.O. E res that the d signed by the be detached	by P		resulting in the underlying cause given in Part L	23e. Did tobacco use contribute to the	
S, F urres n sign	ed	<u>Diabetes mellitus</u>			
cords law requi has been	plet			autopsy prior to co	opsy findings available on mpletion of cause of
of Vital Records, ag Physician: The law require Niter this certificate has been si	Completed			performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	2 No
tal Recionaria The certificate	Be C	25. Was case referred to medical	26 Place of Death (Check	only one)	
Vita nysici this c	0	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other Nursin	ng Home 5 Residence 6 Other:	
n of ing Pl After funera	n: T	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d Describe how injury occurred	-
ion trendi leath. tor:	atio	1 Natural 5 Pending 2 Accident Investigation	1 Yes 2 No		
Division tal or Attendii rs after death.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At h	nome, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rura or Town, State)	al Route Number, City
Divi	če	4 Homicide determined (Specify)  29a Certifier , October Bhasian Table has stranged and services are services and services are services and services and services and services and services are services and services are services and services and services are services are services are services and services are services are services are services and services are services are services are services are services and services are services are services are services are services		<u> </u>	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	Check only   1   Certifying Physician: To the best of my knowled one)   2   Medical Examiner: On the basis of examination is	dge, death occurred at the time, date and place, and and/or investigation, in my opinion, death occurred a	d due to the cause(s) and manner as stated at the time, date and place, and due to the	d. cause(s)
To t with To t	Med	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Mont	
d		1// 1// 1// 1//	O.C.M.E.	January 7, 2010	
OKPER		30. Name and address of person who completed cause of death (Iter		1 ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
100		Melissa Brassell, MD Assistant Medical Exami	· ·	21201	
v S	tate	106			
Regis			J. Sarks		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** 06:00 a.M 19 yeary 2010 lacine ampea /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9. Birthplace (State or Foreign Secon Social Security Number (In yrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Hours Min. 1 □ M 2 1 F 48 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1X Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 14. Race Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐Yes 2 If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: ò 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed within and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a. Informant's Name/Relationship (Type. Print) Ldaughter of Health a 5 one 20b. Place of Disposition (Name of cemetery, crematory or other pi Date 20c. Location -20a. Method of Disposition permit. Pages 1 Department of H Important: If It any injury or c 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mem 4 Donation 5 Dother (Specify) 21. Signature of Eune al Service Licensee 22. Name and Address of Facility 21216 K.M. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. as cardiac or respiratory arrest, Immediate Cause (Final Physician Myorand disease or condition resulting in death) /Medical Due to or as a consequence of) Examiner Sequentially list conditions. ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed Exami en sphe and Due to (or as a consequence of) burial-t P.O. Box 68760. signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐Yes 2 ☐No 2 11 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 □ No 1 🗹 Yes 1 Inpatient 2 PER/Outpatient 3 □ DOA ٩ completely filled in by the funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

30. Name and address

31. Date filed (Month, Day,

ORIGINAL

person who completed cause at death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 12000 th 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Prince Regunal nosintal aurel 7. Age If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 □ 9 218-34-5487 5, Director Nov. 1920 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No MD Prince George's Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 940 Nichols Drive 20707 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14 Bace - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🕅 No Specify. White Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Ø Administrator Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry King Mamie Hatfield ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Wayne Driver/Son 3707 Appleby Court, Glenwood, MD 21738 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt.Airy, MD 1/9/2010 4 ☐ Donation 5 ☐ Other (Specify) Poplar Springs Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral HOme, P.A. M01103 313 Talbott Avenue, Laurel, MD 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shark, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myscandia /Medical Due to (or es e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as e consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burlal-trar Due to (or as a equence Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 Probably 4℃ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No 24a. Was an autopsy 2 🔀 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No s after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

To the Hospital within 24 hours a To the Funeral C

P.O.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

M-1)

29c. License number

D68782

29d. Date signed (Month, Day, Year)

2010

and manner stated.

32. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kowwi Add dy:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dorothy Hammer Duke January 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore County Towson Social Security Number If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 ☐ M 2 🛣 F Months Days Hours Min (Month, Day, Year) Baltimore, MD Director 218-12-7332 86 Usual Residence of Decedent shov 10a. State 10b. County 10c. City. Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Maryland Baltimore Co. Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 504 Surrey Road 21093 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 02 Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Arthur C. Hammer Carrie Goetzke 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chester Arthur Duke, Jr. CLU (Hus 504 Surrey Road Timonium, Maryland 21093 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 10, 1 Burial 2 X Cremation 3 Removal from State Jan. 10 2010 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel Forest Hill, Maryland 22. Name and Address of Facility
Peaceful Alternatives Funeral&Cremation Ctr., P.A. 21. Signature of Funeral Service Lice 2325 York Road Timonium, Maryland par 1. Enter the disease, or complicitions that caused shock, or the strain line. List only one has seen a chiline. sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immunate Cause (Final disease or condition Onset and Death Medical resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last anding physician and use as the burial-trans Due to (or as a consequence of) IF 23

Physician/ Examiner

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 P.O.

Division of Vital Records,

death.

within 24 hours after death To the Funeral Director: / completed filled in by the t

	1 "
sician/Medica	IF 23
Certificate: To Be Completed by Physician/Medica	Pa
o Be Comp	25
Certificate: T	27

Medical

	d		
FEMALE:  b. Was decedent pregnant in the past 13 points? 1 □ Yes 2 D No 9 □ Unknown	23c. If yes, outcome of pregnancy  1		23d. Date of delivery Month Day Year
rt II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?  2 □ No 3 □ Probably 4 ☑ Unknown
		24a. Was an autopsy performed?	
Was case referred to medical	26. Place of Death (Cher	k only one)	

			performed? death?  1  Yes 2 No 1 Yes 2 No		
ı	25. Was case referred to medical examiner?	26. Place of Death (Check o	nly one)		
ı	1 Ves 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	e 5 Residence 6 Other (Specify) Wespile		
	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigatio	(Month, Day, Year) injury work?  1 ☐ Yes 2 ☐ No	d. Describe how injury occurred		
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		

29a. Certifier (Check 2 Medical Examiner: On the bast of my knowledge, death occu only one)  3 □ Certifying Physician: To the best of my knowledge, death occu only one)  3 □ Certifying Nurse Practioner: To the best of my knowledge, death	on, in my opinion, death occurred at the time, date	e and place, and due to the cause(s) and manner stat
29b. Signature and title of certifier	29c, License number	29d. Date signed (Month, Day, Year)

15 State

31. Date filed (Month, Day, Year, JAN 1 1 2010 Registrar

6701 MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			Flease				delible Ink.				•		
			For State	State of Ma	ıryland		artment of F r <i>tificate of</i> .		Mental Hy	•		00060	
			State Registrar  1. Decedent's Name (First, Middle, La	aet)		Cei	tilicate of	Deam	2. Date of D	Reg. No	2010	3. Time of Death	
	Physicia		Edmund	Herman			Elm		Month Janua	Da		11:45 P <sup>M</sup>	
1	/Medic Examin	make	4a. Facility Name (If not institution, given					r Location of Death		-	c. County of Deat		_
فمعر			3605 Eyre Drive	South				Marlboro			rince Ge		
	Funeral			Sex 7. Age 1 🔀 M 2 🗆 F	(In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D 10/29/	rth ay, Year	) Co.	nplace (State or Foreign untry)	1
2	Director		387-26-7798 Usual Residence of Decedent		80	- 1101			10/29/	1929	Wisc	consin	_
	yland now at		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits	
	e Mar 3a-f sl	ctor	MD Prince	George's	JqU	per Ma	rlboro					1 ☐ Yes 2 🔀 No	
	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show sdical Examiner must be notifled at	Director	10e. Street and Number	~			10f. Zip Code	222		10g. C	itizen of What Co	untry?	
	eath v	eral	3605 Eyre Drive	South  12. Was Decedent E	ver in U.S.	13.		0772 Iispanic Origin? (Si	necify Yes or N	0-	U.S.A.	rican Indian,	_
	r iter d	Funeral	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 X Yes 2 □ N			Was Decedent of H		o Rican, etc.)		Black, White	e, etc. nerican	
215-0036	ours a ral', o Exan	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🎛 No	Specify:			Specify: In	ndian	
ئ ا	72 ho "natu dical	etec	15. Decedent's E (Specify only highest gr	ducation rade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor	king	16b. l	Kind of Business/	ndustry	
7	filed within 72 Hygiene. sther than "na ent, the Medic	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		ervisor	<i>3)</i>		Ae	rospace		
7 0	be filed within 72 ho ital Hygiene. d other than "natul event, the Medical	Be Co	17. Father's Name (First, Middle, Las	t)				18. Mother's Nan	ne (First, Middle				_
<u>lan</u>	thould be filed and Mental Hygi marked other matic event, t	To B	Charles			Elm		Rose			Sumn	ners	
Maryland	2 should to and Mening the marker aumatic control of the marker au		19a. Informant's Name/Relationship	(Type. Print)			ng Address (Street					•	
	es 1 and 2 should b of Health and Ments i item 27 is marked r other traumatic e		Liliane Elm / Wit	fe	20h Pla		Eyre Dr	ive Sout	n, Uppe		rlboro,		_
Baltimore,	Pages nent of H int: If ite		1 ☐ Burial 2 ☐ Cremation 3 [		cei	metery, crei	matory or other pla	i i			-		
			4 ☑ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Ana	atomy G	ifts Regist 2. Name and Addre	ss of Facility 7, p.	8/2010	Han	over, Ma	ryland	_
ğ	permit. Departr Imports any inj		1505-	<u>/</u> }			7522 Conn	elley Dr	., Ste.	P,	Hanover,	MD 21076	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused y one cause on each lin	the death.	Do not ent	ter the mode of dyin	ng, such as cardiad				Approximate Interval Between	
3	Physician		Immediate Cause (Final disease or condition	= END	STA	765	PANC	reatic	CAN	ce	r	Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a	a conse ju	ence of):	die-					1,00	
3	g	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Oue to for as a	a conseque	ence of):	118m					413	_
	e executed an and urial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury	/									
	e exec ian an urial-tr	10	that initiated events	C.									
Ď,	e b		resulting in death) Last	c Due to (or as a	a conseque	ence of):							
Q	th ch		resulting in death) Last	c	a conseque	ence of):							_
9/89	certificate be Iding physici Ise as the bu		resulting in death) Last  IF FEMALE:	c							23d Date of del		
Q	death certificat attending phy d for use as th		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	pf pregnan 2 □ Fetal o	icy death 3[	⊒Ectopic pregnanc ⊒ Other ( <i>specify</i> ) _	у			23d. Date of del Month	ivery Day Year	
.O. Box 68/6	the death certily the attending iched for use a		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome   1	pf pregnan 2  ☐ Fetal of time of dea	icy death 3[ ath 5[	Other (specify)	•			Month	Day Year	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Edith Constance January 4, Elliott 2010 5:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurel Regional Hospital Laurel Prince Georges 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🕱 F 049-20-5169 88 Director 01-22-1921 North Carolina Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shorex and continued at Examiner must be notified at 1 ☐ Yes 2 No Director MD Prince Georges Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 and to Health and Mental Hygiene.

ant; if item 27 is marked other than "natural", or items 23a or items up or other traumafic event, the Medical Examine must be not or other traumafic event, the Medical Examine must be 14200 Laurel Park Drive 20707 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify. δ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Henry Wheeler ပ Jennie Bell Paris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine A. Walston - Daughter 1820 Chester Way, Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Marial 2 ☐ Cremation 3 ☐ Removal from State Department of Important; If any injury or once. 01-08-2010 | Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Mem. Park 21. Signature of Funeral Service 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, pr heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis disease or condition resulting in death) days /Medical Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐Yes 2 ☐No Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Arterio Sclerotic Cardiovascular Disease Completed 1 Tes 2X No 3 Probably 4 Unknown Chronic Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 🕅 No 1 ☐ Yes 2 🔀 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 XNo this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After t 28d. Describe how injury occurred 28c. Injury at Work? s after dec. ral Director: After 1x Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Funeral Direc. 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

completely

within 2

(Check only

29b. Signature and title of certifier

Syed Sadiq, MD,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14333

one)

Laurel Bowie Rd.,

29c. License number

D-24721

Ste 208, Laurel, MD 20708

29d. Date signed (Month. Day, Year)

01-05-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10e & 19b, per Fh G899 1/11/10 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year JACK **EPSTEIN** 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Markal Conto MOID Sex 1 M 2 □ F If Under 2 Hours Date of Birth 9. Birthplace (State or Foreign **Funeral**  $61^{rs}$ MA<sup>ntry)</sup> Days Min. Months APR 1948 015-36-6805 **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits be notified at Director MD WORCESTER POCOMOKE CITY 28a-f 1 Yes 2 No 10e Street and Number 425 SHORE 10f. Zip Code ò 10g. Citizen of What Country? Funeral ritems 23a ner must be SHORE LINE LANE 21851 USA Was Decedent of Hispanic Crigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Yes. Give 1 ☐ Yes 2 ☑ No Specify: Specify: Completed 3 Divorced WHITE Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 4 PRINTER SELF EMPLOYED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ of Health and Menta if item 27 is marked r other traumatic en MORRIS **EPSTEIN** MARTHA COVELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. LINDA M. EPSTEIN / WIFE 415 SHORE LA; POCOMOKE CITY, MD 21851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SHARON MEM. PARK 1/11/2010 SHARON, MA Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN RD; BALTIMORE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final arrest 2° To Concer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Examin been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant 9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examine? 1 Ves 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Mipatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner eath Certificate: 28b. Time of 28c. Injury at To the Hospital or Attending F within 24 hours after death.

To the Funeral Director; After 1 atural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number D27820 nunc 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) arrollst. Salisbury MD 21810 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Fe11 2010 6:54 A M Tremlett Thomas January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Gilchrist</u> Towson Baltimore 8. Date of Birth (Month, Day, June 8. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 X M 2 🗆 F Director 216-20-9742 83 Usual Residence of Decedent Show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Examiner must be notified 28a-f 1 Yes 2 No Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21204 U.S.A. 2013 Ruxton Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 → No If Yes, Give 1944—1946 Year or Dates 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: 3 ₩ Widowed 4 Divorced Completed White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Defense Industry Radar Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental H it. Page 1 and 2 should be fill thent of Health and Mental rtant: If item 27 is marked ourly or other traumatic ew Fe11 Kathleen Beale Crawford Edgar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10105 Big Rock Road Silver Spring, Maryland 20901 Charles L. Fell 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 1-15-2010 Maryland Towson 22. Name and Address of Facility of Fure Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ 5mall LUNG un monThis disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year Yes 2 No 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\bowtie$  Other (Specify)  $\bowtie$  Spice 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Known 16 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles ST TON SON HARLA MALIFES MO 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Julia Tebin Frazer 10:20AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 816 Lynn Lee Aberdeen Harford 8. Date of Birth (Month, Day, May 24 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Year 1 □ M 2 ⋤ F Hours Min. Pennsylvania 85 206-12-5905 Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shouy or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Harford Aberdeen Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21001 USA 816 Lynn Lee Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Race - American Indian Armed Forces Black White etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☐**X**No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 XNo Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Service US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Justina Balinska Andrew Tebin 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 735 Carsins Run Rd, Aberdeen, MD 21001 William C. Frazer (son) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Aberdeen, 4 Donation 5 Other (Specify) Harford Mem Gdns. 1/11/2010 Marvland 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A
333 S. Parke St, Aberdeen, MD 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Alzhermev
Die to (or as a consequence of): Immediate Cause (Final Onset and Death Physician/ disease or condition Pars Medical resulting in death) Examiner Sequentially list our ditione, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last cate has been signed by the attending physician page 2 should be detached for use as the burial that the death certificate be 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Box Live Birth 2 L retail Some in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? To the Hospith or Attending Physician; The within 24 hour after death.

To the Funeral Director; Af er this certificate It 1 Yes 2 No Yes or Attending Physician; filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d, Date signed (Month, Day, Year) 2010

Registrar
DHMH 17 Rev 7/2009

State

Pulask

32. Registrar's Signature

2027

Havre De Gray

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#10b, perFH, G899, 1/15/2010, WS
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Peter Harman Goodenow 03, 2010 Medical Jan 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore County 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day Yea April 26 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □**X**M 2 □ F Months Days Hours Min 55 Yrs. Director 042-52-7141 1954 Muncy, PA Usual Residence of Deceden 10b. County 10a, State 10c. City, Town or Location notified at 10d. Inside City Limits Director Harford County Cecil County 28a-f Maryland Havre de Grace 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be n Funeral 709 Giles Street 21078 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ ō 1 Never Married 2 Married filed within 72 hours after 1 ☐ Yes 2 X No Specify: White Specify: "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Health and Mental Hygiene. tem 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Pharmaceutical 12 Manager/Coordinator 04 Trails Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be Robert Harman Goodenow Jacqueline Barey 19a. Informant's Name/Relationship (Type, Print) (mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jacqueline B. Goodenow 709 Giles Street Havre de Grace, Maryland 21078 item 2 Date 10, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ott once, 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State Jan. 10 2010 Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service License Peaceful Alternatives Funeral&Cremation Ctr.,P.A 2325 York Road Timonium, Maryland 21093 Pat. Enforthe diverse, or complications that caused shock, or head failure. List only one cause on each line se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part. Enfort Approximate Interval Between Onset and Death Immediate Cause (Final METAJATIC disease or condition resulting in death) MELANOMA Medical Due to (or as a consequence of): physician and the burial-transit attending pl ed by the detached h? nown lable e of

Physician/ Examiner

Baltimore, Maryland 21215-0036

Box 68760 P.O. certificate has been signi irector, page 2 should be Records, Division of Vital or Attending Physician: after death. director, funeral To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completed filled in by the fun.

al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  C. Due to (or as a consequence of):	
nysician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  \( \subseteq \text{Yes} \) 2  \( \subseteq \text{No} \) 9  \( \subseteq \text{Unknown} \)	d	23d. Date of delivery Month Day Year
Completed by Physician/Medical	Part II. Other significant conditions of	1 □ 24a. Was auto	
Be (	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	-
2	1 Yes 2 No	Hospital: 1	idence 6 D'Other (Specify) hospiw
Certificate:	27. Manner of Death  1 → Natural 5 □ Pending 2 □ Accident Investigatio 3 □ Suicide 6 □ Could not be	28a. Date of injury (Month, Day, Year)  28b. Time of injury  28c. Injury at work?  1  Yes 2  No	how injury occurred
	4  Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (City or To	
Medical	(Check 2 L. Medical Exam	sician: To the best of my knowledge, death occured at the time, date and place, and due to the ci iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the	and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

ST TONSON

2010

State Registrar

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARVES

2010

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32. Registrar's Signature

DHMH 17 Rev 7/2009

(270)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 06 20ÏÖ 2:30 Josephine M. Garrett Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Hampton Meadows 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs, last birthday) **Funeral** Days 0ct 21. 1 M 2 X F Min. 1920 Marÿland 219-16-6686 89 Yrs. **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Towson Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21204 37 Chiara Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Force Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin þ 1 Never Married 2 Married Yes 2 X No 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates White Completed 3 X Widowed 4 □ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Seraphina Rinaudo Tuminello Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37 Chiara Ct. Towson, Md. 21204 Kathleen Ariosa/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Baltimore, Md. Most Holy Redeemer 4 Donation 5 Other (Specify) 1-13-10 21. Signature of Mineral Service License 22. Name an process Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) imel Medical Due to as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe the Hospital or Attending Physician: The this certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 ☑ Other (Specific TED LIVING within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28b, Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury X Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

68760

Box

Division of Vital Records, P.O.

ean

death (Item 23a) (Type,

who completed cause of

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	1- For State Certi	ficate of Death	Reg. No.		
Physician/	Decedent's Name (First, Middle, Last)	Date of Death Month Day Year  1412 been			
Medical Examiner		4b. City, Town, or Location of Death	January 5, 2010 1413 hrs		
)	Facility Name (if not institution, give street and number)     S. Atwood Road	Bel Air	Harford		
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	Date of Birth (MM/DD/YYYY)     9. Birthplace (State or Foreign		
Director	215-03-1407   1XXM 2 F   89	Yrs.	4/19/1920 Country) MD		
à à	Usual Residence of Decedent  10a. State 10b. County 10c. City, To	own or Location	10d, Inside City Limits		
)	MD Harford Bel		1 Yes 2 XXNo		
Maryland 28a-f show any d at once. rector	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?		
r death with the Maryland or items 23a or 28a-f sho must be notified at once. Funeral Director	426 Moores Mill Road	21014	USA		
er death with to or items 23s remust be not	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? ( Specify Yes, specify Cuban, Mexican, Puerto Richard Company Co			
or deat	1   Never Married   2   Married   Armed Forces?   1   Yes   2   X   No   3   X   Widowed   4   Divorced   If Yes, Give Year				
rrs afte	or Dates:	1 Yes 2 No specify:  6a. Decedent's Usual Occupation (Give kind of wor	Specify: white k done 16b. Kind of Business/Industry		
5-0036 ed within 72 hour objection of the mature than "nature medical Exam	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retired			
5-0036 led within 7 Hygiene. other than the Medica	12	Plant Manager	Westinghouse		
D 21215-00°, should be filed within and Mental Hygiene 7 is marked other tingsteerent, the Megantic event,	17. Father's Name (First, Middle, Last)		irst, Middle, Maiden Surname)		
2121; nould be fil ad Mental F is marked tite event, I	Joseph Francis Gessner  19a Informant's Name/Relationship (Type, Print)	Anna M. J  19b. Mailing Address (Street and Number or Rur			
MD 3	Ann Lind-Mattie/ Sister-In-Law		ve, Amelia Island, FL 32034		
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		ce of Disposition (Name of cemetery, matory or other place)	oate 20c. Location - City or Town, State		
imol Pages ment of tant: I		don Park Cemetery   1/9/	2010   Baltimore, Maryland		
Baltimore, M pernit. Pages I and 2 Department of Health Important: If item 2 injury or other traun	21. Signature of Funeral Service Licensee	22. Name and Address of Facility To	wson, Maryland 21204 Home, Inc. 1050 York Road		
	23a. Part I. Enter the disease, or complications that caused the death. D				
Physician IVI edical	failure. List only one cause on each line.	herosclerotic cardiovas	Between Onset and		
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. HYPETERSIVE AT Due to (or as a consequence of):	neroscierotic cardiovas	scular ulsease		
5	Sequentially list conditions,   b.   b.				
ted Insit Examine	cause. Enter Underlying Cause (Disease or injury that initiated				
ecuted t and transit	events resulting in death) Last Due to (or as a consequence of):  d.				
ಲಿ.   ಶ್ರಹ ಡ	V LINDENDED AMENDED				
760, icate be exe sphysician the burial	IF FEMALE: 23c. If yes, outcome of pregnar		23d Date of delivery		
ox 687 eath certifit eath certifit eath certifit for use as the	23b. Was decedent pregnant in the past 12 months?  1 Live birth Pregnant at time of death	2 Fetal death 3 Ectopic pregnancy	y Month Day Year		
Box 68 e death certif the attending ed for use as hysician	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)			
	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.	23e Did tobacco use contribute to the cause of death?		
ords, P w requires the vector of the should be defered be objected by			1 Yes 2 No 3 Probably 4 Unknown		
Records, The law requirer ficate has been sig. page 2 should be Completed			24a. Was an autopsy prior to completion of cause of death?		
tal Rec			1 Yes 2 No 1 Yes 2 No		
Vital Recysician: The his certificate director, page	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 El	26.Place of Death (Check only R/Outpatient 3 DOA Other Nursing H			
n of Viding Physion.  After this funeral differential direction.	27. Manner of Death 28a. Date of Injury 28		d. Describe how injury occurred		
on ending sath.  or: At the fur	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No			
Division of Vital Records, P.O. splial or Attending Physician: The law requires that the ours after death.  neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detack.  Certification: To Be Completed by F.	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At hom	e, farm, street, factory, office building, etc. 28	of. Location (Street and Number or Rural Route Number, City or Town, State)		
Spital Dinneral I	4 Homicide determined (Specify)  29a. Certifier A Continue Physician To the heat of my knowledge.		o, your, state,		
	Certifying Physician: To the best of my knowledge, one)  2 Medical Examiner: On the basis of examination and				
To the within To the comple	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)		
	D-M Lim	O.C.M.E.	January 6, 2010		
	30 Name and address of person who completed cause of death (Item 23	3a)			
	Donna M. Vincenti, MD Assistant Medical Examir	ner 111 Penn Street, Baltimore, MD	21201		
State Registrar	1111 4 4 0040	back			
DHMH 17 Rev 1/2001	7000	ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Physician/ JAWUARY <del>200</del>9 9:50A M RICHARD GREENBERG Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE OWINGS MILLS CHESTNUT COURT If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) Funeral Birtnpia Country) MD 1 X M 2 - F Min. 472071954 217-60-3036 55 Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City. Town or Location 10a, State filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 💢 No MD **BALTIMORE** OWINGS MILLS 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 7 CHESTNUT COURT 21117 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) FOOD SERVICE DESIGN OWNER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည be GREENBERG TRUDY BEHREND PAUL Department of Health and M. Important: If item 27 is mark any injury or other transpore. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHESTNUT COURT, OWINGS MILLS, MD 21117 ESTHER GREENBERG / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State BALTIMORE HEBREW 1/7/2010 REISTERSTOWN, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD, PIKESVILLE, 1 21. Signature / Funeral Service Linen ) e 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician disease or condition Medica resulting in death) **Examiner** Sequentially list conditions, Examine if any, feating to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence oi). signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 Ectopic pregna 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe the Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature pleted cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** ISh /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Yea If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1921 5. Social Security Number **Funeral** 1 🕅 M 2 🗆 F 88 MD 216-14-5908 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County or 28a-f show notified at 10a State 1 ☐ Yes 2 👿 No Director MD Carroll Sykesville 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number ъ ms 23a or must be USA 21784 6512 Marvin Avenue Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 1.π.т. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 X No Specify: White Specify: þ WWII 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry of Health and Mental Hygiene. If item 27 is marked other than "natuor or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Carpenter Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter E. Hush Bertha V. Arrington ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Sue C. Hush (Spouse) 6512 Marvin Avenue, Sykesville, MD 21784 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any Injury or **≒** ö Lake View Mem. Park 1/14/2010 Sykesville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, P.A. P.O. Box 195 Sykesville, MD 21784 0 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery Completed by Be မ Certification:

Hospital or Attending Physician: The law requires that the death certificate be executed s after death.

I Director: Af
d in by the fu within 24 hours aft To the Funeral DI completely filled in

in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Month Day Year								
Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown								
		24a. Was an autopsy performed?  1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No								
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	ne 5 Residence 6 Other (Specify)								
27. Manyler of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury Work?	d. Describe how injury occurred								
3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	nysician: To the best of my knowledge, death occurred at the time, date and place, an miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.									

29c. License number

RE5-000

State Registrar

Medical

29b. Signature and title of certifier

Abtin Khosravi MD 32. Registrar's Signature 600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

2010

January 9th

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month  $20\overset{\text{Year}}{10}$ 1:15 PM Michael Hansel, Sr January <u>Bernard</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Timonium Stella Maris 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 8/27/1926 1 X M 2 D F Months Days Hours Min. Mary land 83 Yrs. Director 217-12-0620 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f s any injury or other traumatic event, the Medical Examiner must be notified. Abingdon MD Harford 1 Yes 2 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21009 U.S.A. 3843 Memory Lane, Apt. A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Forklift Driver</u> Shipping Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Hansel Mary Leonard Heitbuer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Hansel / Wife 3843 Memory Lane Apt. A, Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 1/8/2010 Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Drive, Ste. P, Hanover, 21. Signature of Funeral Service Light MD 21076 23a. Part 1. Enter the disease, we implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition COLON CANCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events southing in death). Let Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🔲 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 X No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 **X** No ည 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28b. Time of 28c. Injury at work?
1 \[ Yes 2 \] No Certificate: 28d. Describe how injury occurred iniury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and tit 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

BERNARD HANSEL

10-00069	
Robert Hicks	

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 00280

Robert nicks		1- For State  1- For State  Certificate of Death  Registrar  Reg. No.	
Physici Medical Exam		1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year  AND Inc.	
incarcar Exam		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	
		Union Memorial Hospital Baltimore	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of Foreign Yrs. Months Days Hours Min. March 28, 1954 Country) M	d.
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside Cit	y Limits
Maryland 28a-f show d at once.	tor	Md. Howard Columbia 1 1 Yes 2	No
e Mary or 28a-	Director	10f. Zip Code 10g. Citizen of What Country?	
with th ns 23a be notii	ral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Blace)	×,
r death or iter	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.	,
urs afte tural",	d by	3 Vildowed 4 Divorced in tes, cive rear 1 Yes 2 No specify: Specify: Specify:	
6 172 ho an "na ical Ex	ete	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	Co.
1215 be file antal Hy rked o	Be	Joseph Hicks. Theressa May	
D 21 should and Me 7 is ma	၉	19a. Informant's Eme/Relationship (Type, Print) (5,15ter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip ode)	045
e, M l and 2 Health item 2		20a. Method of Disposition   20b. Place of Disposition   20b. Place of Disposition   20c. Location - City or Town, State	1121
MOF Pages nent of ant: If		1 Donation 5 Other Specify: Garrison Forest 1/15/2010 Dwings Mills.	Md
Balti permit. Departi Import		21. Signiture of Funeral Service Ligensee 22 Name and Address of Facility 05eph L. Russ Funeral Home P. A.	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate	
Wedical Examiner		failure. List only one cause on each line.    Immediate Cause (Final disease a. Acute bronchopneumonia complicated by hypothermia   Death	
		or condition resulting in death)  Due to (or as a consequence of):	
	iner	Sequentially list conditions,  If any licating to immediate  Due to [or as a consequence of]:  cause. Enter Underlying Cause	
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
68760, certificate be executed nding physician and se as the burnal - transit	calE	d.  X UNPENDED  AMENDED  D AMENDE	-
'60, ate be o	Physician/Medical	AMENDED 23a,PII,27,28a-f,permE, g900 2/3/10 TT 23d. Date of delivery	-
certific	ian/	23b. Was decedent pregnant in the past 12 months?  4 Pregnant at time of death 5 Other (Specify)  Month Day Ye	ar
cords, P.O. Box 6876 law requires that the death certifica has been signed by the attending phe should be detached for use as the	hysic	1 Yes 2 No 9 Unknown 9 Unknown	
P.O. that the ned by detach	by P		
Division of Vital Records, P.O tall or attending Physician: The law requires that it and refred death.  **A Director: After this certificate has been signed by the funeral director, page 2 should be detacted.	Completed	24a. Was an 24b. Were autopsy findings a	vailable
ecords he law requi te has been ge 2 should	duc	autopsy prior to completion of car performed? 1 ✓ Yes 2 No 1 ✓ Yes 2	
ian: Tien: Tien: Certifica	Be	25. Was case referred to medical 26. Place of Death (Check only one)	
of Vit Physic er this c	P	1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Nursing Home 5 Residence 6 Other:	
ON O cnding ath. or: Aft	Certification:	1 Natural 5 Pending (Month, Day, Year) 1 Yes 2 No subject exposed to cold subject exposed to cold	
ivisi or Att after de Directe	tifica	2 X Accident   Investigation   Fd. 1/3/2010 FD 6:25 pill	er, City LV Pkw
Ospital hours a uneral			
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical	2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
E 3 F 8	Me		
		My hu, hu?  O.C.M.E.  January 5, 2010	
		Name and address of person who completed cause of death (Item 23a)     Ling Li, MD	
S Regis	ate		
Regis	uell	MULT # COLO   MANAGE   1. 17	

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State	of Mar			rtment of l	Health and I Death		giene Reg. No.2	010	002	189
		1. Decedent's Name (First, Middle, Last)  2. Date of Death										3. Time of	Death
Physicia Medic		Fyrangeline S. Howell Month Day								Year 2010	8:30	$a^{M}$	
Examin									unty of Death				
- 4 <sup>f</sup>	Sanctuary at Holy Cross						Burtons			M	ontgome	ery	
Funeral Director		5. Social Security Number 577-40-9846	6. Sex 1 ☐ M 2 <b>X</b> XF	7. Age (In	n yrs. last birth		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da August	th y, Year) 18,19	Coun	place (State or try) DC	Foreign
d it	_	Usual Residence of Decedent  10a. State 10b. County		10	Dc. City, Town	orloc	ation				1.	0d. Inside Cit	. Limite
arylan a-f st fied a	Director	MD Montgo	omerii	"	Silver							1 🗌 Yes	-
or 28	ä	10e. Street and Number	Onici y		DIIVOI		10f. Zip Code			10o Citizen	of What Coun		2 23 110
with t s 23a ust be	Funeral	1116 Briggs Cha	ney Road				20905			USA	or trial oou.	,.	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If then Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☒ Marria 3 ☐ Widowed 4 ☐ Divorced	If You G	orces? 2 🔀 No ive	r in U.S.	if	/as Decedent of F Yes, specify Cuba ☐ Yes 2 🛂 No	lispanic Origin? (Span, Mexican, Puerto Specify:	oecify Yes or No- o Rican, etc.)		Race - Americ Black, White, e cify: white	etc.	
hour natu	lete		nt's Education		16a.	Decede	ent's Usual Occup	oation		16b. Kind o	of Business Inc	lustry	
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and 2 lealth im 27 her tr		Cheryl A. Moore	/ Daughte					Point Ro	d., New				
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permit Depart Impor any in		21. Signature of Funeral Service L	icensee	м0.	1053	22. 31	Name and Addre	ss of Facility Do	onaldson	Funer MD 20	al Hom	e, P.A	•
		23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that	caused the	e death. Do no	ot enter	the mode of dyir	ng, such as cardiac	or respiratory an	rest,		Approximate Interval Betw	
Physician/	3 3	Immediate Cause (Final disease or condition	1.00	1	e to t	hr	ive					Onset and D	
Medical Examiner		resulting in death)	Due to	(or as a co	onsequence o	f):	Irome						
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ath certifica attending p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou			3 □	Ectopic pregnan	CV		23d.	Date of delive	ery	
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Attending Physician: The law requires that the death certificate be executed refeath. After this certificate has been signed by the attending physician and sy the funeral director, page 2 should be detached for use as the burial-transi	Completed								24a. Was autop perfo 1  Yes	rmed2	b. Were autor prior to cor death? 1 \(\sum Yes\)	npletion of ca	vailable luse of
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Phys this ral dir	<u>۱</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 28a. Date		2 ER/Out			4 Wursing H	lome 5 Resid				
ending eath. or: After he funer	Certificate:	1 Natural 5 ☐ Pendin 2 ☐ Accident Investi	gation (Moi	nth, Day, Ye	ear) 200. The	jury	28c. Injur worl M 1	y at <br   Yes 2 □ No	28d. Describe h	iow injury occ	curred		
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To the Hospital or Attending Planswithin 24 hours affer death.  To the Funeral Director. After the completed filled in by the funeral	Medical	(Check 2 Medical E	Physician: To the xaminer: On the ba Nurse Practioner	isis of exam	nination and/or	investig	gation, in my opini	on, death occurred	at the time, date a	nd place, and	due to the cau	ise(s) and man	ner stated.
To t with To t		29b. Signature and title of certifier	0 00	0.011	. A.A	<u></u>	29c. Licens			29d. Date sig	ned (Month, I	Day, Year)	
9		30. Name and address of person	who completed cau	ise of death	n (Item 23a) (T	ype, Pr	int)	)006986					
U		Tehseen R. Naq				ve.	Suite	203, Balt	ımore,	MD ZIZ	U 9 		
Stat Registra		31. Date filed (Month, Day, Year)  JAN 1 1 201	O Lever	Registrar's	Signature	res.	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11.557 M Month 2010 Sung Duck Kim FAUNT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BACTMORE WASHINGTON MEDICAL CIL POUIZINIE ANNE 5. Social Security Number 6. Sex If Under 24 Hrs. If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 X M 2 🗆 F Months 10-02-1929 Director 213-02-1856 Korea Usual Residence of Decedent show 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Examiner must be notified at Director or 28a-f MD 1 Yes 2 No Anne Arundel Severn 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a Funeral 7907 Tressel Court 21144 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 K Married þ 1 ☐ Yes 2 🗓 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Asian Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Assemblyman Electric Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) In Soo Kim Sang Lyang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Byong Kun Kim - Son 7907 Tressel Court, Severn, Maryland 21144 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Meadowridge Mem Pk. 01-12-10 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 18 Bro MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death BiANDEZ Physician/ METACTATEC Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown n signed by the at 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 No Yes 2 N 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital 2 No Other: 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated nd title of certifier 29c. License number Mil 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hogaral 301

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Knight SHELBY **Physician** DANUARY 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 - F Months Days Min Hours 31 Yrs. 217-92-444 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show event, the Medical Examiner must be notified at 19 Yes 2 □ No Director MI +more 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21206 23a Funeral items Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examiner once. 1 Never Married 2 Married 1 ☐ Yes 2 K If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ployed 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Knight inne ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, ip Code) 19a. Informant's Name/Relations (Type. Print) brother Balto Ave, Itamilton ากกล rennaro 20a. Method of Disposition
1 Berial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2010 Dr 16 2612 Donation 5 Other (Specify) 21. Signature of uneral Service Licens 22. Name and Address of Facility towell nera 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SUBARACHNOID HEMORRHAGE ANGURYSMAL **Physician** disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) or Attending Physician; The law requires that the death certificate be executed for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Tectopic pregnancy Month Day in the past 12 months? 4 - Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 ☐ Unknown 1 Yes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 6 C Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation Injury 1 Tyes 2 No to the Hospital or Attendil within 24 hours after death. To the Funeral Director: A the 3 
Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) filled in by 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely (check only end manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

18

Registrar

30. Name and address

MANJUNATH

RES 000

600 North Wolfe St, Baltimore, MD, 21287

MD

f person who completed cause of death (Item 23a) (Type, Print)

MARKANDAYA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** KIRK AR GARE 01 06 2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, Year) 08/18/1924 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🕱 F 230-24-5745 85 V۸ Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Macdical Examine or man has a second 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 5076 Orville Avenue 21205 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 👿 No Specify Specify: 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Assistant State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be White D. Mary Minton В. Kinzer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stan Kirk, Son 22 Crows Foot Drive, North East, MD 21901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Park 01/12/2010 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc. Candrasell 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NEVMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ ARTERY STENOSIS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed PIDE LAT Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 2 No 1 ∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation ours after death.

leral Director; A
filled in by the fu 1 ☐ Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated.

P.O. Box 68760. Division of Vital Records.

> State Registrar

DHMH 17 Rev 1/2001

h Raven Boulevard Battimore

VICENIE MACO-FURES

res 5601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jamuary 5, 2010 6:55  $p^{M}$ Philip Т. Klima Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1500 LaTrobe Park Terrace Baltimore n/a Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month Day Yearne 7. 193 Hours Min. Waryland 214-26-2492 Director 78 June Usual Residence of Decedent permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD n/a Baltimore 1 🔀 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 USA 150 LaTrobe Park Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 x No Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Baltimore City Police Officer Baltimore Police æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Richard Klima Agnes Ehart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Klima wife 1500 LaTrobe Park Terrace Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State January 11,2010| Brooklyn, Maryland Holy Cross Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 21. Signature of uneral Service Licensee Baltimore, MD 21230 130 E. Fort Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ensiun To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the luneral director, page 2 should be detached for use as the burial-transit that initiated events Due to ( a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Stroke 1 Yes 2 No 3 Probably 4 Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 4638 6,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Janet O'Mahoney 301 St. Paul Street Baltimore, Maryland 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State Registrar	State of	Marylan		artment e rtificate			Mental Hy	giene Reg. No. 2	2010	00286	
and the		_	1. Decedent's Name (First, Middle, Last)  2. Date of Death								Year	3. Time of Death		
Physician Yetta S. Lodge								Januar	y 7 i	12:10 A M				
500	Examin		4a. Facility Name (If not institution	er)			wn, or Loca	tion of Dea	ath	4c. Co	unty of Death			
	Keswick  5. Social Security Number  6. Sex  7. Age (In yrs. last birthe							imore Year   If U	nder 24 Hr	s. 8. Date of Bi	rth	N/A	place (State or Foreign	
v	Funeral Director		212-07-1813	1 M 2 XF	94			Days Ho			17, Year)	Cou	England	
	- Mg **		Usual Residence of Decedent											
	ırylan show	Bear .	10a. State 10b. County			y, Town or Lo							10d. Inside City Limits  1 ☑ Yes 2 ☐ No	
	he Ma 18a-f otifie	Director	Md. N/A		Dd	ltimor	10f. Zip C	odo		<del></del>	10a Citizen	of What Cou		
	with the Maryland a or 28a-f show t be notified at		10e. Street and Number 3378 St. Be	anadict St				1229			rog. Onizon	Engla	,	
	leath ns 23 musi	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.	S. 13.			ic Origin?	(Specify Yes or Nerto Rican, etc.)	0- 14.	Race - Ameri	Ican Indian,	
9	after o		1 ☐ Never Married 2 ☐ Marr	ied Armed Forci 1 Tyes 2 If Yes, Give	. □YNo	1	ır res, specin 1 ⊟ Yes 2 [		exican, Pue ec <i>ify</i> :	erio Rican, etc.)		Black, White		
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show dical Examiner must be notified at	Completed by	3 XWidowed 4 ☐ Divorced	Year or Dat	es:				,-			. W	hite	
15-(	י קטל ר "natı edica	lete	15. Decedent (Specify only highes	st grade completed)		16a. Dece Give	dent's Usual ( kind of work DO NOT use	Occupation done during retired)	most of w	rorking	16b. Kina	of Business/I	ndustry	
12	within iene. than " the Mec	m o	Elementary/Secondary (0-12)	College (1-4	lor 5+)	i	Clerk	,			Comme	rcial	Credit	
br	be filed within 72 ho ttal Hygiene. id other than "natu event, the Medical	BeC	17. Father's Name (First, Middle,	Last)				18. 1	Mother's N	ame (First, Middle	e, Maiden Su	rname)		
ylar		2	Solomon Sai						_eah	Piaster				
Maryland	S S S		19a. Informant's Name/Relations		<b>+</b>					Rural Route Num . Ellic				
d)	l and deal		Mrs. Marian McC	ain/ Daugn	20b. F	Place of Dispo	sition (Name	of	וט שכ	Date		tion - City or T		
nor	ages ent of it: If it		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			dens o			. 1-	8-10	Balt	imore,	Md.	
Baltimore,	permit. Pages 'Department of H Important: If ite any injury or of		21. Signature of uneral prvice							n Fu <u>n</u> era		_		
m	Deg any			1/1/		10		1050	ork /	Rd. Tows	on, Md	2120	4	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that can	used the deat ch line.	h. Do not en	ter the mode	of dying, su	ch as card	iac or respiratory	arrest,		Approximate Interval Between Onset and Death	
-	Physician /Medical Examiner	n	Immediate Cause (Final disease or condition resulting in death)	_a	ngest	ine he	art	face	livre				Incek	
			resulting in death)	Due to (o	uence of):	ie stensis						Iweeb.		
6 0.5		ē	Se uentially list conditions, if any, leading to immediate	b. Due to (u) as a consequence of).										
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0,	be executed sician and burial-transit	Ĕ	resulting in death) Last	Due to (o	r as a conseq	uence of):								
09289	the age	dical		d										
9 X	leath certific attending p	Physician/Med	IF FEMALE:	23c. If yes, outc	ome pf pregna	ancy					230	d. Date of deli	verv	
Вох	atten I for u	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live bir	th 2 ☐ Feta int at time of c	al death 3	⊒Ectopic pred ⊒ Other <i>(sp</i> ed				200	Month	Day Year	
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	w requires that s been signed t should be det	by P	Part II. Other significant condition	ons contributing to dea	ath but not res	sulting in the u	inderlying cau	use given in	Part I.				the cause of death?	
ord	equire sen si	ted								-   1	Yes 2.2471	No 3∏Pro	obably 4 □Unknown	
Records,	a taw r nas be e 2 sh	Completed								24a. Wa	opsy	24b. Were au prior to d death?	topsy findings available completion of cause of	
a F	siclan: The law s certificate has t irector, page 2 s									1□ Yes	formed? 2 ☑ No	1 ☐ Yes	2□ No	
Vital	Physiclan: this certific al director,	Be (	25. Was case referred to medica examiner?  1 ☐ Yes 2 ☐ No	Magnital:	patient 2	IER/Outnatie	nt 3□ DO∆	Other:		Death (Check only		Other (Spec	nife()	
ō	Phy rald	n: To	27. Mann f Death	28a. Date o	·	28b. Time of Injury		c. Injury at Work?	LIFINUISIII		Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred			
ion	Attending Ir death. ector: After by the funer	atio	1 V atural 5 ☐ Pendir 2 ☐ Accident investi	gation	i, Day Teal)	linjury	М	1 ☐ Yes	2 🗆 No					
Division	or Attend after death, Director; /	tific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	Linear I Zoe, Place (	of injury - At h g, etc. <i>(Speci</i>	ome, farm, st	reet, factory,	office			(Street and I own, State)	Number or Ru	ıral Route Number,	
Ω	Hospital of the Hospital of Funeral Districts filled in	Cel	29a. Certifier 1 Certifyii	ng Physician: To the	bact of my kny	owledge dea	th occurred a	t the time d	ate and ni	ace and due to th	e calleg(e) as	nd manner as	etated	
9	io the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Medical Certification:		Examiner: On the ba	sis of examina									
	ro the within 2 To the comple	Me	29b. Signature and title of certifie				29c.	License nur			29d. Date s	signed (Monti	h, Day, Year)	
5			> 17 Isabelle	Vacqu	eger or	0		013	657	7	Jahr	vary 7	,2016	
			30. Name and address of person	who completed cause	of death (Iter	m 23a) (Type 60 W-4	Print)	TREET	, B1	ALTI DE OR	B, 779	2121	1	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2010	gistrar's Sign	ature	N.							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MORTON Month Year 2010 1607PM JOSEPH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY MONTGOMERY GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 5, Social Security Number 9. Birthplace (State or Foreign Funeral 1 **X**M 2 □ F Days 08-3-1921 Washington, DC 88 Yrs. Director 579-42-2774 Usual Residence of Decedent Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Md. Prince Georges Capitol Heights 10e. Street and Number 10g. Citizen of What Country? by Funeral 20743 U.S.A. 9404 Dogwood Park Street 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2 \( \text{No} \) 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: Black If Yes. Give 3 ¥ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) d 2 should be filed with alth and Mental Hygien. Custodian Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Bertha Matthew Morton Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 si Department of Health ar Important: If item 27 is any injury or other Joseph М. Morton - Son 9404 Dogwood Park St., Capitol Heights, Md. 20743 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Heritage Memorial PK: 1-08-2010 | Waldorf, Maryland 22. Name and Address of FacilityRonald Taylor II Funeral Home 21. Algnature of Funeral Service Licensee 10583 Middleport Lane, White Plains, Md. 20695 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RIGHT MASSIVE MCA disease or condition Medical resulting in death) Examiner SHOCK SEPTIC PNEUMONIA WITH if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exam FAILURE burial-transit ACUITE RENAL Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical DIABETES IE EEMALE yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? HYPERLIPIDEMIA Jas autopsy performed? completed filled in by the funeral director, page Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes \_ 2 ☐ No Be 26. Place of Death (Check only one) မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Hospital or Attending Phys 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined e Funeral I Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number D59418 JANUARY 4, 2010 MD Isaurennz, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

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Baltimore, Maryland 21215-0036

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Records,

Division of Vital

QEWUNMI
32. Registrar's Signature

MD

MONTGOMERY

GENERAL HOSPITAL

Please Type or Print in Black Indelible Ink. / Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month p M 2010 Jacqueline May Moore January 4:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George Laurel Regional Hospital Laurel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 ☐ M 2 🕱 F 045-26-4481 75 Aug. 25, 1934 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🕅 No Glenwood MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21738 3054 Hobbs Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2KM Arried 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Department Store 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Meyers Walter Cornwell 19b. Mailing Address (Speet and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3054 Hobbs Road, Glenwood, MD 21738 Melvin R. Moore/ Husband Date 7, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 Odenton, MD West Arundel Crem. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. + Kein Slikes 313 Talbott Ave., Laurel, MD 20707 M01053 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ٦ day disease or condition resulting in death) Septic Shock Due to (or as a consequence of): Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chronic Obstructive Pulmonary Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ∐Yes 2 🖳 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 A Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 12XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

burial-transi and Box 68760, P.O. Records, Division of Vital

Hospital or Attending Physician: The law requires that the death certificate be executed funeral after death Director: filled in by the e Funeral I

**Physician** 

Examiner

**Funeral** 

Director

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items 23a

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Is marked other than

of Health a

Department of H Important: If Iter any Injury or oth Once.

**Physician** 

/Medical

Examiner

Pages 1 and 2 should

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Director

Funeral

Completed by

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Examiner

Physician/Medical

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Completed

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Medical Certification: To

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(Check only

29b. Signature and title of certifier

29a. Certifier

traumatic event, the Medical Examiner must be notified at

be filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

/Medical

within 2.

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed Sadiq, MD, 14333 Laurel-Bowie Road, Suite 208, Laurel, MD 20708

and manner stated.

32. Registrar's Signature

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D24721

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) January 6, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** 2010 anuar Kal /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 **X**M 2 □ F 59 219-50-2595 MD Director 4/1/50 Usual Residence of Decedent pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a ~ 000. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State MD N/A Baltimore 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 7002 Arion Ave 21234 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify:American þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Self Elementary/Secondary (0-12) College (1-4 or 5+) Musician 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Purnell Owens Garic Owens 19a. Informant's Name/Relationship (Type. Print)
Lakia McGill/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7002 Arion Ave, Balt., MD 21234 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem. 20a. Method of Disposition Date 1/14/10 1 XBurial 2 Cremation 3 Removal from State Balt., MD 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Li 22. Name and Address of Facility Hari P. Close F. 21206-5105 5126 Belair Rd, Balt., MD 23a. Part 1. Envir v./ disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lear failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Ectopic pregnancy Year in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 No Yes 9 Unknown Division of Vital Records, P.O. þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner?
1 \subseteq Yes 2 No Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 Pending investigation 1 🗌 Yes 2 No 2 Accident after death 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide thin 24 hours a 29a. Certifier (check only 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES ODD

State Registrar

31. Date filed (Month, Day, Year) JAN 1 1 2010

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Greenbaun

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ JANUARY 2010 **MOLBOGOT** 11:16A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1112 COCKEYS MILL ROAD REISTERSTOWN BALTIMORE Social Security Number 6. Sex 1 💢 M 2 🗆 F 9. Birthplace (State or Foreign Country) NJ 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 082-14-2181 89 *ซีซีทีซี (*ซีซี (ซีซี (ซี Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No BALTIMORE MD REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1112 COCKEYS MILL ROAD 21136 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Was Decedent Ever Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. 3 X Widowed 4 □ Divorced Specify: Completed WHITE 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic avent, the Me once. UNITED STATES Elementary/Seconday (0-12) College (1-4 or 5+) 12 POSTAL WORKER POSTAL SERVICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ KLEIN LENA **SCHLOS** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELENE POLICAR / DAUGHTER 1112 COCKEYS MILL ROAD, REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify BALTIMORE HEBREW 1/8/2010 REISTERSTOWN, MD f Funeral Servi ve Lice (see Sig 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) percending efficien Medical Due to (or as a consequence of) Examiner 10 years lymphone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of physician and sthe burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? detached for Dav Pregnant at time of death
Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown hypernephron Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural Natural 5 Pending injury Accident
Suicide 1 ☐ Yes 2 ☐ No. Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number Kehendo Seng AD DOOZOGCY Horyland 1/4/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mont

4450, 10755 Felix Rd, Lullerville, Ad 21093

32 Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Angelina A. Minacapelli 2010 4:20 P. January 8, Medical 4a. Facility Name (if not institution, give street and number)
Franklin Woods Nursing Facility 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Rosedale . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🏻 F Months Hours Min JUN 97th 13 4, 1909 Maryland 100 214-18-3816 **Director** Usual Residence of Decedent 10b. County N/A or 28a-f shov Maryland 10c. City, Town or Location Baltimore 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be Funeral 21214 USA 5907 Glen Oak Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 🛣 No If Yes, Give þ 1  $\square$  Never Married 2  $\square$  Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Woolworth Dept. Stroe Unknown Salesclerk Be 18. Mother's Name (First, Middle, Maiden Surname) JOSEPHINE UNKNOWN 7. Father's Name (First, Middle, Last) ဂ္ Petro LeVolsi 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 12470 S.E. 179th Street Summerfield Florida 34491 Peter Minacapelli/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) Entonoment Gardens of Faith 2/13/10 Baltimore Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Leonard J. Ruck, Inc 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner DOVERN Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of and I-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-t Physician/Medical Box 68760 signed by the attending p d be detached for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 9 I Inknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 2 🗌 No certificate Yes 2 N 1 Yes of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Natural Assider 5 Pending Division 1 🗌 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Ocertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nursa Practioners To the best of my knowledge, death obnumed at the time, date and plane, and due to the cause(s) and maximum as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D23465 1/10/ JM30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd. 2845 Glen Burnie am Moneses 32. Registrar's S State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 09<sup>Day</sup> 2010<sup>Year</sup> Physician/ Jan. 7:47 P.M Gary Christopher Newport Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Baltimore County Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🕱 M 2 🗆 F Months Days Hours Min (Month, Day, Year Director 213-52-7071 Tuly 09.1947 Baltimore MD Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location within 72 hours after death with the Maryland 10d Inside City Limits Director 1 Yes 2 XNo Maryland Baltimore County Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21057 11639A Long Green Pike United States 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates.Vietnam 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Hotel Maintenance Worker permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hugh Montraville Newport Irene Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms.Paula B. Hill (Friend) 11639A Long Green Pike Glen Arm, Maryland 21057 Date 11, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Jan. 4 Donation 5 Other (Specify) Evans Funeral Chapel 2010 Forest Hill, Maryland 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P.A Signature of Funeral Service Licens Timonium, Maryland 25 York Road 23a. Par 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ OblAS TUMA Multi Forma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been shown the state of the funeral Director. Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Vear Month Pregnant at time of death certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 3 Probably 4 Unknown No . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy the funeral director, page death? 1 Yes 2 🗌 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 📉 No 1 Tes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident Suicide iniury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1441 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 6

NO

32. Registrar's Signature

HARUES

31. Date filed (Month, Day, Year)

TOWION

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PI line a-b, per MD 8899 1/20/10 TT

State of Maryland / Department of Health and Mental Hygiene 00293 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Robert Charles Neiman 07, 10 · 15₽ Medical January 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Co Towson Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** 9. Birthplace (State or Foreign Days 1**X** M 2 □ F Months Hours Country) Director Yrs. 193-18-5628 84 April York PA show death with the Maryland 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🔽 No Baltimore Co. Maryland Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12300 Rosslare Ridge Road 21093 Unit 407 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 ☐No Specify: "natural", Specify: 3 Widowed 4 Divorced W.W.II White Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 04 Public other Accountant Accounting other traumatic event, Be If the stand 2 should to arthurn of Health and Mental Hy arthment of Health and Mental Hy " frem 27 is marked of " arthur atto eve 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Ernest Edward Neiman Grace Lucille Singley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Elizabeth Neiman (wife) 2300 Rosslare Ridge Rd. Timonium, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Jan.10, 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) 2010 Forest Hill,Marvland . Signature of Funeral Service Licenspe 22. Name and Address of Facility
Peaceful Alternatives Funeral&Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Pneumonia** 23a. Onset and Death Days Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Pulmonary Fibrosis vears Sequentially list conditions, Examiner If any leading to in medicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day page 2 should be detached i 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 autopsy certificate 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner?
1 \sum Yes Hospital 2 **X** No Other: Certificate: To 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 IDOA Director: After this 27. Manner of Dea h 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident
Control
Contr Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital o within 24 hours aff To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature of certifie 29c. License number 29d. Date signed (Month, Day, Year) 68104 8 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3120 MI 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Ye ar **Physician** MARION PLAT 2017 INGV VARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6. Sex 775P17A) RANDALLSTV BALKIMDR NOUTHWES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 215-22-7312 1 □ M 2 X F MARVIAND Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Reisterstown BALTIMORE MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 6 21/36 U.SIA. 12020 Reisters "natural", or items 23a Funeral to WN 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ò Specify: BLACK 3 Widowed 4 □ Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene, Important: If item 27 is marked other than any injury or other traumatic event, In Men Elementary/Secondary (0-12) College (1-4or 5+) LAUNDRY LAUNDRY AID 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SMALLWOOD BARBEE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CLAIRINGE ROAD EDWARD POWR Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 13/2010 LANSDOWNE, MARY And 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The DERRICK C. JONESFIH, P.A. 4611 PARK HGTS. AVE., BALTIMORE, MARVIANO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANTERIOSCLERD 12 LAROIDVASCULAR **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list commons, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a d be detached for 1 ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 K No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25/No 1∏Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To nours after death.

neral Director: After this filled in by the funeral di this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifie 000024970 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Date filed (MonJAN 1ª1 2010

12 Registrar's Signature 1. Jacks

O, RANDALLSTOWN MAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00295 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** 7: 05 PM Barbara Margaret Phelan 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A HOSPT MORB If Under 24 Hrs AGNES 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 10/23/1923 1 □ M 2 □ XF Months Days Hours Min 216-16-4250 86 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, its itselical Exarction must be notified at 1 ☐Yes 2 → No Director Maryland Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5938 01d Washington Road 21075 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White ۵ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bartells Brothers Office Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental John Eichelman Barbara Goeller ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i Nadine Jakubowski/ Daughter <u> 3315 Belsford Court,Dundalk,Maryland21222</u> permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other 1 once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial 1/11/2010 |Elkridge,Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 7250 Washington Blvd., Elkridge, Maryland., 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4 days UMONI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executer Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ⊌nknown HEAR Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □No 1 □Yes 2√No 1 ☐ Yes Hospital or Attending Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No Certification: To Nonpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ohit 1-24063

State Registrar

Baltimore, Maryland 21215-0036

BARA

2

ELAN,

Records,

Division of Vital

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

BALTIMORE

2010

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 1 1 0 296 State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of D	eath	Reg	g. No.					
Physicia		Decedent's Name (First, Middle,Last)		2. Date of Death Month	Day Year	3. Time of Death 1802 hrs				
িdical Exami	ner	Dinda laccerson	City, Town, or Location of Deal	January 8,	4c. County of Death					
			Baltimore		N/A	<u> </u>				
Funeral Director		0.000.00	f Under 1 Year If Under 24Hr Months Days Hours Mi	<b>—</b>		nplace (State or ntry)SC				
ź.		Usual Residence of Decedent  10a, State 10b. County 10c. City, Town or Location				10d. Inside City Limits				
Maryland 28a-f show any d at once,	tor	MD N/A Baltimore				1 Yes 2 No				
with the Maryland ms 23a or 28a-f sho be notified at once	Director	1731 N. Ellamont St.	Of. Zip Code 21216		g. Citizen of What Count					
r death	y Funeral	1 Never Married 2 Married Armed Forces? If Yes, 1 Yes 2 No	ecedent of Hispanic Origin? (S specify Cuban, Mexican, Puert s 2 X No specify:		14. Race - Americ White, etc. African Specify Amer					
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after the freath and Mental Hygiene. tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Completed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's t during most	Jsual Occupation (Give kind of of working life. DO NOT use recer Cutter	work done tired)	16b. Kind of Business/Ir Meat	dustry				
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Con	17. Father's Name (First, Middle, Last) George Patterson	18.Mother's Nam Mary C	e (First, Middle, Ma anty	aiden Sumame)	-				
ore, MD 2121 ss I and 2 should be fill of Health and Mental I If item 27 is marked her traumatic event,	10		dress (Street and Number or J. Ellamont							
Baltimore, permit. Pages I and Department of Heal Important: If item injury or other tra		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:	cematory 1/	13/10	20c. Location - City or 1 Hanover, M	D				
Baltimore permit. Pages I Department of I Important: If Injury or other		21. Signature of Fun ra Service licensee 22. Nam 512	e and Address of Facility Ha: 26 Belair Rd	ri P. C Balt.,	lose F.Sv MD 21206-	S1PA 5105				
Physician // // // // // // // // // // // // //		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the n failure. List only one cause on each line.				Approximate Interval Between Onset and				
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. narcotic and cocaine using the properties of the pro	se complicated	by hypo	thermia	Death				
		Sequentially list conditions, b								
	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated								
outed nd transit	I Examiner									
760, icate be executed physician and the burial - transit	ledical	X UNPENDED X AMENDED PIT per ME g90 23a,27,28a-f,p	ermE, g900 2/1	9/10 TT						
Box 68760, he death certificate be the attending physic refer use as the but	Physician/Me	4 V 2 No O - 4 Helmoure -	death 3 Ectopic pregn	ancy	23d. Date of delivery  Month Da	ay Year				
b. Bc the dea	Phy	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tob	acco use contribute to the	ne cause of death?				
ires that the signed by it be detached	ą	Asthma		1 Yes	2 ✔ No 3 Proba	ibly 4 Unknown				
rds, requires been should	Completed			24a. Was ar autopsy		opsy findings available impletion of cause of				
Reco	omo			perform 1 Yes 2		2 No				
tal Rec	BeC	25 Was case referred to medical examiner? Hospital: 1 Invariant 2 FR/Outnationt 3	26.Place of Death (Check							
of Vil ling Physic After this funeral dir	٩	1 V Yes 2 No Hospital 1 V Inpatient 2 ER/Outpatient 3  7. Manner of Death 28a. Date of Injury 28b. Time of Injury		ng Home 5 R	esidence 6 Other: winiury occurred used drugs	and ring				
on on cending sath.	ţį	1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 X No		a cold env					
Division of Vital Records, pital or Attending Physician: The law requir ours after death.  reral Director: After this certificate has been sifilled in by the funeral director, page 2 should	Certification	2 X Accident Investigation 3 Suicide 6 Could not be determined (Specify) house	actory, office building, etc.	28f. Location (Strong Town, Standar)	reet and Number or Rus ate) 1731 N E1 e MD	Route Number City				
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the state of t	Medical C	29a. Certifier (check only one)  Certifying Physician: To the best of my knowledge, death occurred one)  Medical Examiner: On the basis of examination and/or investigation,	at the time, date and place, and in my opinion, death occurred	d due to the cause at the time, date ar	(s) and manner as stated and place, and due to the	1. cause(s)				
S in	ĕ	29b Signature and title of certifier	29c. License number		29d. Date signed (Mont	h, Day, Year)				
Dona		Mayarte The Youle	O.C.M.E.		January 10, 2010					
14		30. Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111 Penr	Street, Baltimore, MD	21201						
St Regist	ate rar	31. Date-filed (Month, Day Year) 32. Registrar's Signature			OUME					

		_	For	eartment of Health and Nertificate of Death		10 0000
			Hegistrar	ertilicate of Death	Reg. No	3. Time of Death
	Physicia	ın	1. Decedent's Name (First, Middle, Last)  Stewart P. Seitz, Sr.		Month Day  January 1	y Year 5.20 amay
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c.	County of Death
	LXamm	Ç1	3303 Hooper Road	New Windsor		Carroll
	Funeral		Social Security Number     6. Sex     7. Age (In yrs. last birthda)	/) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
	Director		220−16−0098	Monard Bayo	Apr 26 19	24 MD
	ㅁ .		Usual Residence of Decedent  10a State 10b County 10c, City, Town or	agation		10d. Inside City Limits
	show	_	10a. State 10b. County 10c. City, Town or New Win			1 □Yes 2 <b>X</b> No
	e Ma Airfi	었		10f. Zip Code	10g Ci	tizen of What Country?
	ith th	Dire	10e. Street and Number		US	
	s 23a	ra	3303 Hooper Road	21776		14. Race - American Indian,
92	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Modical Eventinal remaint or notified at ance.	y Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No WWII	Was Decedent of Hispanic Origin? (Sp If Yes, specity Cuban, Mexican, Puerto     □ Yes 2 □ No Specify:	Rican, etc.)	Black, White, etc.  Specify: white
21215-0036	hours tural"	Completed by	3 ☑ Widowed 4 □ Divorced Year or Dates:	cedent's Usual Occupation		Kind of Business/Industry
15	n 72 "nat	lete	(Specify only highest grade completed) (Gi	ve kind of work done during most of work . DO NOT use retired)		alth come
112	filed within Hygiene. <b>yther than</b> '	ЩC	Elementary/Secondary (0-12) College (1-4or 5+)	urse	ne	ealth care
<b>d</b> 2	12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than " traumatic event, the Me.	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Maider	
Maryland	ld be ental ked ic ev	To B	Clarence Seitz	Bertha A	Agnes Holla	ınd
ary	shou nd M mar	-		iling Address (Street and Number or Ru		
	1 and 2 Health a tem 27 Is		Adrienne C. Crace (granddaughter) 30			
ē,	s 1 a		20a. Method of Disposition 20b. Place of Discemetery, c	position (Name of rematory or other place)	Date 20c. L	ocation - City or Town, State
E	Pages nent of hant. If ite			ew Memorial 1-14	-10   Syk	esville, MD
Baltimore,	permit. Pages 1 ar Department of Hes Important: If item any injury or othe once.		21. Signature of Funeral Service Licensee	HAIGHT FUNERAL HOMI PO Box 195 Sykesvi	E & CHAPEL,	P.A. 84
			23a Part 1 Enter the disease, or complications that caused the death. Do not			Approximate Interval Between
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition  Congestive	1 1 7 1		Onset and Death
	Physician /Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	, main facili		11.
-	Examiner		Boo to (a) de d sallesquares x.).			
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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ó	cate be executed oblysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
8760,	ate be nysici he bu	ical	d			
39	ing pl	Med	IF FEMALE:			COLD II of delivery
Box 68	requires that the death certificate be executed seen signed by the attending physician and nould be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year
0	n requires that the deben signed by the should be detached	hysi	9 Unknown			
Ф.	s that med l	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		o use contribute to the cause of death?
Ğ	quire an sig uld b	ed b	Chronic Kidny Disease		1 🗆 Yes	2. No 3 Probably 4 Unknown
တ္		Completed	14 v pertension		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
æ	siclan: The law certificate has to irector, page 2 s'	E	Aprilo Stenosis		performed2	death?
ta	an: rtifica tor, p	Be C	25. Was case referred to medical	26. Place of Dea	th (Check only one)	
>	Physiclan: this certific al director,		examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	itient 3 DOA Other: 4 Nursing F	lome 5 Residence	6 ☐ Other (Specify)
Division of Vital Records,	Attending Physiclan: r death. ector: After this certific by the funeral director, I	Certification: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) Inju	ry Work?	28d. Describe how in	jury occurred
jo	ttendin death. ctor: Af y the fur	atic	2 Accident investigation	M 1 □Yes 2 □No		
<u>vis</u>	r Atte er de recto	ţį.	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
Ö	tal or rs aft al Di	Cer			L	(-) day
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, of the basis of examination and/one)  29 Medical Examiner: On the basis of examination and/one and manner stated.	reath occurred at the time, date and place or investigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	and place, and due to the cause(s)
	the thin the orthe	Mec		29c. License number	29d. I	Date signed (Month, Day, Year)
	Z × Z		MMZ M.D.	D33681	1	-11-2010
	7		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)	2011	14.5
1			M.K. MEEVOY 1380 Progress	Way, Suite 114	Eldersbir	m MD 21784
1	St	ate	31. Date filed (Month, Day, Year) 22. Registrar's Signature	and the second		Ø
	Regist	Irar	JAN 1 1 2010 Jentin B. A.	D33681  pe, Print)  Way, Suite 114	<del></del>	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM# 10ex 19a, perFH, G899, 1711/2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Horace Sasser, Sr. J. 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Hospital Bayview Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 09-04-1940 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 212-36-0004 1 XM 2 □ F NC 69 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ortant; if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the results I Evan in the notified at MD Baltimore Dundalk 1 ☐ Yes 2 XNo Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7415 <del>Dunman Way</del> Dunmanway 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Superintendent Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( should be fand Mental Eva Price Byron Sasser ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7415 <del>Dunman Way,</del> Baltimore, MD 21222 Pages 1 and 2 s ment of Health ar Elizabeth Sasser / Wife 20c. Location - City or Town, State Date 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages Department of Important; If it any injury or or W. Arundel Crematory | 01/12/2010 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Rendon-Bailey Funeral Home, 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately Course (Filed). undial Infores Immediate Cause (Final disease or condition resulting in death) 8826 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) ☐Yes 2☐No the 9 Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Rial Division of Vital Records. Be Completed by Fibrellation 3 Probably 4 Unknown 1 Yes 2 No funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4  $\square$  Nursing Home 5  $\underline{\square}$  Residence 6  $\underline{\square}$  Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Yes 2 No Medical Certification; To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 24 hours after death.

Funeral Director: A completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number undoh MD DOD12975 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD-447N-KENWOODAVE BALTO MD 2/204 K'RAMAIAH 32 Registrar's Signature Date filed (Month, Day, Year) State Sime B. face Registrar DHMH 17 Few 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician **VERA** F. STRAUGHN \_a <sup>M</sup> 5:30 2010 <u>January</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOLLOW RUN FOX Anne Arundel Pasadena If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Feb. 19, Social Security Number **Funeral** Year) Hours Months Days Min 1 □ M 2 ▼F Virginia 1924 Director 254-26-3799 85 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examinar must be notified as once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland <u> Anne Arundel</u> Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 U.S.A. 1806 Fox Hollow Run 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify þ Specify: 3 Twidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 N/ASecretary MD. Refrigeration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Calldwell Lee <u>Marjorie</u> Edward <u>Shanks</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Dewey E. Straughn (Son)</u> <u>1806 Fox Hollow Run Pasadena, Maryland 21122</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Cremation C 01/08/10 Glen Burnie, Maryland 21. Signature of Juneral Service Licensee McCully-Polyniak Funeral Home, P.A. 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smooth, Corner (Figure 1). Approximate Interval Between Onset and Death Immediate Cause (Final Physician CEREBROVASCULAR ACCIDENT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CALDIO VASCULAR DISASA MIGRIOSCLERUTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) □Yes 2 100 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 14 No 1 Tyes Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1∐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending s after decentary series of filled in by the investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical **Topletely** (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number a Relled JANUARY 8, 2010 21776 NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANDLER ST #200 BACTIMORE MU 3001 32. Registrar's 31. Date filed State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-00300 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** STUART Τ. OH: OH am VIRGINIA )anuary 2010 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TIMORE ST. Agnes HOSPITA Ja N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 M 2 F 87 219-16-5823 31, 1922 Virginia Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show id other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Catonsville Directo Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 U.S.A. 719 Maiden Choice Lane #514 Chapel Court Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White Maryland 21215-0036 1 □Yes 2 No Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, The Medie once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) American Red Cross Social Worker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edna Catheryne Brownley Joseph Finch Foster Jr. ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 North Carolina Avenue, Pasadena, Maryland 21122 S. Feeney (daughter) Dianne Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park Jan. 11, 2010 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21. Signature of Fun Service Licenses 3204 Mountain Road, Pasadena, Maryland 21122 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. I mediate Cause (Final leease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of in any, leading to immediate cause. Enter Underlying Cause (Disease or injury executed signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) o 9 Unknown ے 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 No 1 □ Yes Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1/☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide At Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c<sub>4</sub> License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) Cationscalle hour Lane, Registrar's Signature 31. Date filed (Month, Day, Year)

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State

Registrar

JAN 1 1 2010

Lar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101	State of M	arylan					lental Hyg	iene		
			State Registrar			Cer	tificate o	f Death	h	F	leg. No.2	10	00301
	Physicia	n/	1. Decedent's Name (First, Middle, Last)							<ol><li>Date of Dear Month</li></ol>	Day	Year	3. Time of Death
	Medic	al	Alan Robert Tho  4a. Facility Name (if not institution, give stre				45 Ch T-		of Dooth	Jan. 8	8, 2010 6:30 4c. County of Death		
	Examin	er	3501 Chaneyvill				4b. City, Town, or Location of Death Owings				4c. Count		vert
	Funeral		5. Social Security Number 6. Sex	7. Ag	e (In yrs. la	st birthday)	If Under 1 Ye	ar If Unc	der 24 Hrs.	8. Date of Birth		9. Birthp	lace (State or Foreign
	Director		278-40-2367 1XIN	12 🗆 F	64	Yrs.	Months Da	ys Hour	s Min.	2 / 23 / 1	9 4 5	Count	IN_
	nd at	L	Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Loc	ation					1	0d. Inside City Limits
	arylar a-fsl ified	Director	MD Calver	+	,	•		Owinc	TC.				1 X Yes 2 □ No
	or 28 e not	Dir	10e. Street and Number				10f. Zip Cod				10g. Citizen of	What Coun	try?
	s 23a rust b	Funeral	3501 Chaneyvill	e Road			] :	20736	5		τ	JSA	
	death item			Was Decedent E Armed Forces?			/as Decedent o	of Hispanic of Useria	Origin? (Spe can, Puerto l	cify Yes or No- Rican, etc.)		ce - America	
50	after al", or xami	d by	1 ☐ Never Married 2 🗶 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 If Yes, Give Year or Dates.	No 7	2 1	☐ Yes 2 🔀	No Spec	ify:		Specify		nite
ş	hours natura ical E	Completed	15. Decedent's Educa	tion	3 / <del>-</del> / .	16a. Deced	ent's Usual Oc	cupation		T	16b. Kind of E		
9500-612	in 72 e. nan "r Med	ошо	(Specify only highest grade of Elementary/Seconday (0-12)	completed) College (1-4 or 5	i+)		ind of work do. NOT use retir		nost of workii	ng			,
7	ygien ygien her th	Be C		<u> </u>		Nuc]	lear E	ngin	eer		Powe:	r Pla	nt
yland	he filed ntal H ed ot ever	70 B	17. Father's Name (First, Middle, Last)  Robert Thornton					18. Mo		e (First, Middle, N		ne)	
Š	ould bud Me mark		19a. Informant's Name/Relationship (Type,	Print)		10h Mailin	a Addrage /Str	oot and Nun		n Toml I Route Number,		State Zie C	ada)
Mar	12sh althar 27is rtrau		Arlene Thornton	,	٠	1	-			oad, O			*
e,	of Hex of Hex fitem		20a. Method of Disposition		20b. Pl	lace of Dispos	sition (Name of atory or other		•		20c. Location		
Ĕ	Page ment ant: If ury or		1 🔀 Burial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)	noval from State		Mem'	1 Gar	dens	1/13	/10	Dunkiı	ck, M	D
baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Livensee	2		22.	Name and Ad	dress of Fac	cility Ra	ymond-	Wood I	г.н.,	P.A.
_	= # O	_	0.0115	_		P	O Box	430	<u>Dun</u>	kirk,	MD = 20	754	
	F91 .		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one commediate Cause (Final	ause on each line	the death	1 4		-	1		-		Approximate Interval Between Onset and Death
	Ph_sician/ Medical	1	disease or condition resulting in death)	Due to (or as a	2 0000000		4300	P	ANCL	EANC	(ANG	en	Onset and Beaut
	Examiner			Due to (or as a	a consequ	ence org.							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseque	ence of):							
	cuted ind transit	xam	Cause (Disease or iinjury that initiated events c.	5 / /									
	ate be executed physician and the burial-transit	dical Examiner	resulting in death) Last	Due to (or as	a conseque	ence of):						!	
9	cate by physics the b	an I	d										
000	certifi nding use as	Z/W	IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome	of pregnan	псу	<b>.</b>				23d. Da	ate of delive	rv
Ž D D	Attending Physician: The law requires that the death certifica et edath.  rector, After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as it	Physician/Me	in the past 12 months? 1  Yes 2 No	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			Other (specify						Day Year
5	t the c by th stache	Phy	9 Unknown			hat a discount		1 i. D.		T			
r.	es tha igned be de	þ	Part II. Other significant conditions contrib	outing to death b	ut not resu	uiting in the ur	derlying cause	given in Pa	art I.				e cause of death?
	requir	etec											
Vital Records,	e law thas b	Completed								24a. Was a autops perforr	y	prior to con death?	sy findings available npletion of cause of
ř	in: The ificate or, pag	ပိ	25. Was case referred to medical			-	26	Place of D	eath (Check	1 🗆 Yes		1  Yes	2 🗌 No
VIE	ysicia s cert direct	To B	examiner? 1 \( \sum \) Yes 2 \( \sum \) No	oital:	ent 2 🗆 E	ER/Outpatient	1	7thou		me 5 Reside	ence 6 Oth	ner (Snecify)	
5	ng Ph ter thi neral		27. Manner of Death  1 Natural 5 Pending	28a. Date of inju	ry	28b. Time of injury	28c. Ir	ijury at ork?		28d. Describe ho			
JIVISION OT	tendir leath. or: Af the fu	iţica	2 Accident Investigation 3 Suicide 6 Could not be		, ,			Yes 2	□ No				
<u>S</u>	or At after c Direct in by	Certificate:	4 Homicide determined	28e. Place of Injubul building, etc			et, factory, offic	ce	1	28f. Location (St. City or Town		er or Rural i	Route Number,
ב	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Physicia	n: To the best of	my knowle	edge, death o	ocured at the ti	me, date ar	nd place, and	d due to the caus	se(s) and mann	ner as stated	i.
ĺ	ne Ho in 24 f ne Fui pletec	Medical	(Check 2 Medical Examiner: only one) 3 Certifying Nurse Pr	On the basis of e	xamination	and/or investi	gation, in my op	oinion, death	occurred at	the time, date an	d place, an <b>d</b> du	e to the cau	se(s) and manner stated.
1	Vith Com		29b. Signature and title of certifier	1 1	Pn	ysiahn		nse numbe			9d. Date signe		
	1.		Nalles	1 Pan	dy		M	n Dog	36650	Finally -	JANV	arry	11, 2010.
			30. Name and address of person who comp	eted cause of d	0			NAM			agos	1	
	Stat	e	22 S. GNEENE S 31. Date filed (Month, Day, Year)	32. Redistra	/	ar mo u	i pr	<u>الحرا</u>	2120				
	Registra		MAN 1 1 201	O Dear	·	1. 1	all						

10-00115
Sharon Thomas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 00302

		1- For State Registrar	Certi	ificate of Dea	ath	Reg	. No.	
Physici Medical Exami	an/	1. Decedent's Name (First, Middle,La	Thomas			2. Date of Death Month [ January 4, 2	Day Year 2010	3. Time of Death 1744 hrs
		4a. Facility Name (if not institution, gi Johns Hopkins Hospital		Balt	r, Town, or Location of Dea timore		4c. County of Death	4
Funeral Director		212 02-1112-1-	ex 7. Age (In yrs. las	st birthday) If Ui Mor	nder 1 Year If Under 24H hths Days Hours Mi		Foreig	thplace (State or in untry) Md
Maryland 28a-f show any d at once,	ctor	Usual Residence of Decedent  10a State 10b. County  10e. Street and Number	A 10c. city, T	own or Location	I C	10g	. Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No
eath with the Maryland items 23a or 28a-f sho ust be notified at once,	al Director	318 S. He	12. Was Degedent Ever in U.S.	. 13, Was Dece	2/23/ Ident of Hispanic Origin? (	Specify Yes or No-	US/	ican Indian, Black,
면 등록	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorce	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	If Yes, spe	ecify Cuban, Mexican, Puerl	o Rican, etc.)	White, etc.  Specify: Bl	ack
2 3	Completed b	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of v	al Occupation (Give kind of vorking life. DO NOT use re		6b. Kind of Business/	Home
	å	17. Father's Name (First, Middle, Las	omas	10h Mailing Addre	18.Mother's Nam	ne (First, Middle, Ma	phnson	Zin Code)
sho and and nati	2	Mrs. Annette  20a. Method of Disposition	Mills-Conner	2656 ace of Disposition (N	W. Garris	on Ave	Butto. 20c. Location - City or	Md 21215
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traus		1 Burial 2 Cremation 3 4 Donation 5 Other Specify 21. Signature of Funeral Services	removal from state	ematory or other place	Crematory //	12/2010	Balto.	Md.
Physician Department of the property of the pr		Hatelle 7. 23a. Part I. Enter the disease, or com	plications that caused the death. I	L. 2252P	W. LiRuss A	or respiratory arres	Home P.	Approximate Interval
Examiner		failure. List only one cause on e Immediate Cause (Final disease or condition resulting in death)	.Complications o Due to (or as a consequence of):		c mellitus			Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):					
ecuted and - transit	I Examiner	(Disease or injury that initiated events resulting in death) Last						
e ex	Medical	X UNPENDED			899 1/25/10	TT	23d. Date of deliver	
Box 68760, he death certificate by the attending physic hed for use as the bunkel	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 ✓ Unknow	23c. If yes, outcome of pregnated 1 Live birth 4 Pregnant at time of the death 9 Unknown	2 Fetal dea 5 Other (Si		nancy		y Day Year
P.O. E es that the igned by the be detached	d by Phy	Part II. Other significant conditions  Obesity	contributing to death but not res	sulting in the underlyi	ing cause given in Part I.		acco use contribute to	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t	Completed					24a Was an autopsy perform	prior to death?	topsy findings available completion of cause of es 2 No
Vital ysician: his certi	B	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 ✓ E	R/Outpatient 3	26.Place of Death (Check DOA Other Nurs		esidence 6 Othe	
on of \ ending Phy ath. or: After th	tion: To	27. Manner of Death  1 X Natural 5 Pending	(Month, Day,Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe ho	w injury occurred	
Divisior  pital or Attend  ours after death  teral Director: filled in by the 1	Certification:	2 Accident Investiga 3 Suicide 6 Could no determine	t be 28e. Place of Injury - At hon	ne, farm, street, facto	pry, office building, etc.	28f. Location (Str or Town, Sta		ral Route Number, City
To the Hosp within 24 ho To the Fune completely f	Medical C	one) 2 Medical Examine	cian: To the best of my knowledge er:On the basis of examination and and manner stated.	d/or investigation, in	my opinion, death occurred	at the time, date ar	nd place, and due to th	e cause(s)
	Ř	29b. Signature and title of certifier	inst		O.C.M.E.		29d. Date signed (Mo January 6, 2010	nth, Day, Year)
		,	istant Medical Examiner	111 Penn Str	eet, Baltimore, MD 2	1201		
S Regis		31. Date filed (Month, Day, Year)	32 Registrar's Signature	barre	•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician January 445M 2010 LUBOY\_ TSYGANOVA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY SINAL HOSPETAL OF BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 12/21/1915 9. Birthplace (State or Foreign Country) RUSSIA 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Hours 1 □ M 2**X**□ F 94 Director 124-80-1629 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits LUBOU TSYGANOVA ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho. Injury or other traumatic event, the Medical Exa. sinst must be notified at Director 1 X Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5906 PARK HEIGHTS AVENUE, #510 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🖫 No Specify: WHITE Completed by Specify: 3€XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Gollege (1-4or 5+) Elementary/Secondary (0-12) **HOMEMAKER** OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental I Important: If item 27 is marked of any Injury or other traumatic even once. Mental CHAYA **ZACHAR** FRIED UNKNOWN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TATYANA BECHATNIKOVA/DAUGHTER 2901 FALLSTAFF ROAD,#308 BALTIMORE, MD 21209 Patient Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
ANSHE VESHEAR CEM. 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/08/2010 | BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between poset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final STROKE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cauca (Lisease of Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be executed sician and burial-trans Due to (or as a consequence of): 68760. attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a o. 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ DIABETES MELLITUS 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 2 No 1 □ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death,
To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifie

SHAILENDRA 31. Date filed (Month, Day, Year)

Shailendra

JAN 1 1 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SINGH, MD

32.

egistrar's Signature

SINAL

29c. Lîcense number

RES. 000

HOSPITAL OF

29d. Date signed (Month, Day, Year)

BALTIMORE

JANUARY 7, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death dent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner If Under 1 Year If Under Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 📈 M 2 🗆 F Months Days Hours Min. Month, Day Country) **Director** 10d. Inside City Limits or 28a-f show 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State **Funeral Director** 1 X Yes 2 □ No more 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces:

1 X Yes 2 If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DQ NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Be 18. Mother's Name (First, Middle, Maigen Surname) 17. Father's Name (First, Middle, Last) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (SUN) or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21 Signatur Fymeral Service Lice 22. Name and Address of Fatil Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Oneet and Death Immediate Cause (Final disease or condition Carcinoms Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last the burial attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death detached 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide work? 5 Pending 1 🗌 Yes 2 🗌 No death. Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 00043375 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAREN W. METULITT 28.35 SMITH ANE, BALTIMOLE, MI) SUITE 203 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2010 9:30 January Phyllis Medical Marie Witkus 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Baltimore 812 South Woodlynn Road If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year 9/16/1926 1 □ M 2 🎗 F Months Days Hours Min Director 220-22-8918 Pennsylvania Usual Residence of Decedent show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Baltimore Essex 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 812 South Woodlynn Road Α. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. Elementary/Seconday (0-12) College (1-4 or 5+) Aero Space 8 Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ruehl Gallagher McCoy orene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale E. Gardner (Daughter) South Woodlynn Road Maryland 21221 Essex, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 1/9 2010 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore City, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Fastern Avenue Maryland 21221 23a. Part 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Hemorrhad Immediate Cause (Final Wo grach not d Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially ist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death ed by the a detached f 1 ☐ Yes 2X 9 ☐ Unknown After this certificate has been signed by funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician; The law requires to bours after death.
 Funeral Director: After this certificate has been sign 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes ပ္ 2**XX**No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Investigation Accident completed filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number MD of death (Item 23a) (Type, Print) Bultmore MD 21221

Registrar
DHMH 17 Rev 7/2009

State

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Anna Marie Wegeler 2010 3:00 8. January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Timonium Maris If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🔽 F Director 133-16-8910 92 31, 1917 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, tre Medical Exacities must be cutfind at 1 □ Yes 2 □ No Director N.J. Somerset Basking Ridge 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 07920 U.S.A. by Funeral <u>17 Berkeley Circle</u> Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 □Yes 2 TNo Specify: 3 V Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other traumatic event, It a Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Family/Personal Personal Secretary Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be McMahon ျ Charles Henry Annie Leavy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 07920 19a. Informant's Name/Relationship (Type. Print) 17 Berkeley Circle Basking Ridge, New Jersey <u>James Wegeler</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 YBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-12-2010 Basking Ridge, N.J. Holy Cross Cemetery 21. Sig 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** weeks orona /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit death certificate be executed Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) I □Yes 2⊠No Ö 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed Vital 1 ☐Yes 2 🗷 No 2 XNo After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Division 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the formal completely filled in the formal completely fi investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) SME 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) 2300 DULANEY VALLEY ROAD ERNESTINE WRIGHT, M.D. TIMONIUM MD 21093 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State Registrar

DHMH 17 Rev 1/2001

RANUARY

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Howard Lyons Wilson 7:45 P M January 5, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Woodstock Baltimore 10037 Davis Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year **Funeral** Months Days Hours Min. 213-18-2327 17 M 2 □ F 92 Yrs. Sept Director 29,1917 Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 XXVo Director MD Baltimore Woodstock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10037 David Avenue 21163 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XXes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 □No Specify. '45-'46 Specify: White 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Service Man Gas and Electric 17. Father's Name (First, Middle, Last)
Howard Lyons Wilson 18. Mother's Name (First, Middle, Maiden Surname) Be ( Christina Dude 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trau Pages 1 and 2 Lorraine Lowe (Daughter) 10037 Davis Avenue Woodstock, Maryland 21163 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park | Jan 9,2010 | Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signation of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd . Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** sheraling /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Year Day 5 ☐ Other (specify) o∏Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 No Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 5 Pending ours after death.
neral Director: Al
filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier / 022/1 DAMEM BURDKESS

State Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Registrar's Signature

FREDERICK RO, SUDTE 18

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BACTANRE

MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jamüarv Pay 2010 1:12 Carolyn J. Arrington Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Carroll County Hospital Westminster If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1948 Days Hours Month Bay, 1 M 2X F Maryland 61 Jď'n Director 217-52-4643 Usual Residence of Decedent show 10d. Inside City Limits 10c. City. Town or Location 10a, State within 72 hours after death with the Maryland Examiner must be notified at Director 28a-f 1 Yes 2 X No Baltimore Parties Owings Mills Md. ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21117 USA 2 Oakmere Rd. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examine 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Maintenance Retail Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ Margaret Zentgraft Howard Arrington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ms. Catherine Arrington/ Sister 2 Oakmere Rd. Owings Mills, Md. 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hill Cemetery 1-14-10 22. Name and Address of Facility Funeral Home, Signature of Funeral Service Licensee York Rd. Towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine riany, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and burial-tran resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 Yes 2 No certificate Yes 25. Was case referred to medical Be 26, Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate:

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director.

29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifie

MORIAL AVÉ

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

WESTMINSTER

State

Medical

1 Matural

2 Accident

3 ☐ Suicide 4 ☐ Homicide

BEHARI 200 31. Date filed (Month, Day, Year)

JAN 1 2 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending

Investigation

determined

6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** William R. Ayres Jr 3.21 /Medical 2010 January, PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Air 1 Year | If Under 24 Hrs. Harford 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) Mar 17, 1932 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 M 2□ F 77 Mar 213-30-1133 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examinat must be mailed at 1 ☐Yes 2☐No Director Baltimore Hydes 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6836 Park Forrest Lane 21082 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify. Specify: white þ 3 Widowed 4 Divorced **1**52**-**54 Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other than 0 cialist US Govt, APG
18. Mother's Name (First, Middle, Maiden Surname) equipment specialist 17. Father's Name (First, Middle, Last) Be William Russel Ayres Catherine Marie Neuner 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret L. Ayres/spouse 6836 Park Forrest Lane Hydes, MD 21082 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signafure of Funeral Servi 22 Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street S. Vade Director 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, the heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -Physician ISCHEMIC CARDIOMYUPATHY YEARS \*/Medical Due to (or as a consequence of) CORONAM Examiner ARTER XEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ing physician ar Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) ned by the a 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 1 → Patient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar ason Birnbaum, M.D.

31. Date filed (Month, Day, Year)

JAN 1 2 2010

Moude

DO0296

500 Upper Chesaporte Dr. Bel Air, MD 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 23a per dr.,g899.01/112/10dhb,31
Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LETTIE ANDERSON AM JANUARY 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ef baltimore Sinai hospital Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6 Sex 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🖵 F Months (Month, Day, Year) Country) Director 216-42-6552 Oct-4, 1943 **Maryland** Usual Residence of Decedent 3a or 28a-f show t be notified at 10b County 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland N/A **Baltimore** 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral Examiner must 508 McMechen Street 21217 U.S.A tems Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. "natural", or i à 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates. Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Rosewood Hospital Nurse Aide 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ည Silas Anderson Rena Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Donna Holland 3404 Dennlyn Road Baltimore, Maryland 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/08/09 Brooklyn Park, Md. Cedar Hill Cemetery & Mausoleum 21. Signature of Funeral Service Lansee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failuse. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Due to (or as a consequence of): Medical Examiner End Stage Renal Disease Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or iinjury tuge reach ancon and that initiated events resulting in death) Last the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No for Pregnant at time of death Month Dav Year be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown peen: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe After this certificate 1 ☐ Yes 2 🗷 No Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 No မ 1 Main Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No M Accident Investigation the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined To the Hospital within 24 hours a To the Funeral D Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 [ only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03,2010 Januar RES 000 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) , Beluedon he, MD-712 Bulhmore 12401 11. Date filed (Month, Day, Year) 2010 32. Regi State Registrar

**ORIGINAL** 

DHMH 17 Rev 7/2009

10-00064	
Bruce Boblitz	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

luce Dobiliz		1- For State	tate of Maryland	-	tificate of D		entai mygiene		201	0031
Physici	an/	Registrar  1. Decedent's Name (First, Midd	ile,Last)		inouto or B		2. Date of	Reg. No. Death		3. Time of Death
/ledical Exami		Bruce Edwa	rd Boblit	Z			Month Januar	y 3, 201	O Year	1400 hrs
)		4a. Facility Name (if not instituti		)		City, Town, or Location	on of Death		c. County of Dear	
P		4807 East Joppa Roa				ottingham			Baltimore Co	,
Funeral Director		5. Social Security Number 215–60–5007 Unk	6. Sex 7. Ag	le (In yrs. Ia				27.1	[ Coro	rthplace (State or gn ountry) MD
any		Usual Residence of Decedent  10a. State  10b. County		10c. City,	Town or Location					10d. Inside City Limits
<b>*</b>	Ļ	MD Bal	ltimore	P	erry Ha	11				1 Yes 2 No
Maryland 28a-f show 1 at once.	Director	10e. Street and Number				f. Zip Code		10g. Cit	izen of What Cou	intry?
vith the Maryland 23a or 28a-f sho notified at once.		4807 E. Jop	pa Road	Ever in 11 9		21128	Origin? ( Specify Yes or		.S.A.	rican Indian, Black,
eath w	Funeral		Armed Forces				can, Puerto Rican, etc.)		White, etc.	
ifter d	by Fi	3 Widowed 4 Di	1 Yes 2	No No	1 Yes	2 No spec	ify:		Specify: W	nite
iours a		15. Decedent's Education (Spe	ecify only highest grade con	npleted)		sual Occupation (Gir f working life, DO N	ve kind of work done	16b.	Kind of Business	Industry
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once.	ompleted	Elementary/Secondary (0-12)		5+)	Engine	•	OT use remed)		Hospit	al
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle Raymond Bobl					ner's Name (First, Midd Ssie Eile			
e, MD 21215-0036  1 and 2 should be filed within 72 Health and Mental Hygiene. item 27 is marked other than 'i	To	19a. Informant's Name/Relations Vernon Bobli		•	1		lumber or Rural Route Ct., Jop			e, Zip Code) 085
		20a. Method of Disposition		20b. PI					Location - City or	Town, State
More Pages 1: nent of H ant: If it		1 Burial 2 Cremation 4 Donation 5 Other S	n 3 Removal from Sta	Che	sapeake	Crem.	01.11.1	0 Be	1tsvil	le, MD
Baltimore, permit. Pages 1 at Department of Her Important: If ite		21. Signature of Funeral Service		1447	22. Name	and Address of Fac	CAFA/St Pastures	ephe Dr.	n D. L. Balto	ohrmann,PA , MD 21286
Physician		23a. Part I. Enter the disease, or	complications that caused	the death. I	Do not enter the me	ode of dying, such as	s cardiac or respiratory	arrest, sho	ock, or heart	Approximate Interval
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. Metha by hypot Due to (or as a conse	hermi	and alpra <u>bronch</u>	azolam int opneumonia	toxication a and hypot	comp.	Licated La	Between Onset and Death
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Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial—transi	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	ne of pregna	incy			230	d. Date of deliver	, <u>, , , , , , , , , , , , , , , , , , </u>
ceath certificat eath certificat a attending phi	cian	past 12 months?	1 Live birth 4 Pregnant at	time of deat	2 Fetal de		pic pregnancy		Month I	Day Year
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od by t	y Phy	Part II. Other significant condit	tions contributing to death	but not res	ulting in the under	lying cause given in	Part I. 23e. Di	d tobacco	use contribute to	the cause of death?
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of Vital Records, ig Physician: The law requirement. The table there this certificate has been some and director, page 2 should law.	ompleted							topsy		topsy findings available completion of cause of
Rec The la	E							erformed? es 2 N	death? o 1 ✓ Ye	es 2 No
	Be C	25. Was case referred to medica examiner?					th (Check only one)			
Physic r this	2	1 <b>✓</b> Yes 2 No	Hospital: 1 Inpatie		R/Outpatient 3	DOA Other			nce 6 🗸 Othe	
	on:	27. Manner of Death  1 Natural 5 Pend 2 X Accident Inve	ding stigation 28a. Date of Inju (Month, Day,Y)	ear)	28b. Time of Injury 2 <b>d 1:57 p</b>	28c. Injury at Wo	subje	be how inju ct ex conmen	posed to	cold
Division pital or Attendi ours after death teral Director: /	Certificati	3 Suicide 6 Coul			ne, farm, street, face	tory, office building,	etc. 28f. Locatio or Town <b>Nottin</b>	n (Street a	nd Number or Ru	ral Route Number, City oppa Rd
		29a. Certifier (Check only 1 Certifying P	hysician: To the best of my	knowledge	, death occurred a		place, and due to the c	ause(s) an	d manner as state	
To the within To the comple	edical		miner: On the basis of exar	nination and	Vor investigation, in					
V per	Σ	29b. Signature and kitle of certific	1 9/1	MOS	V	O.C.M.E.	er		Date signed <i>(M</i> o uary 4, 2010	nth, Day, Year)
101		30. Name and address of person	who completed cause of d	eath (Item 2	3a)					
IV		Victor Weedn MD JD	Assistant Medical			Street, Baltimo	ore, MD 21201			
St Regist	ate	31. Date filed (Month Day Year)	32. Registrar	Orginality	Ce Kal					

DHMH 17 Rev 1/2001 OCME 2006

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last)

**Physician** /Medica Examine **Funeral** Director

**Physician** /Medical Examiner

Division of Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran To the Hospital or Attending Physician: The law requires that the death certificate be exect

hysicia Medic/		John Walter Banaskiewicz,	Jr.			January [	6, 20/0	1256pM			
Examin		4a. Facility Name (If not institution, give street and number)	40	4b. City, Town, or	Location of Death	ty 1	c. County of Deat	th /			
unoral		5. Social Sectify Number 6. Sex 7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birt	thplace (State or Foreign			
uneral rector		218-58-9059 12™ 2□F 56	Yrs.	Months Days	Hours Min.	(Month, Day, Yea Jul 15,	1953 M	aryland			
>		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Lo	- tion				10d. Inside City Limits			
shov sd at	ا ا					1- Yes 2 □ No					
28a-f	Director	MD Ba	altimo	10f. Zip Code		10a. (	10g. Citizen of What Country?				
3a or		611 South Charles Street		2123	)		United States				
ms 2	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13.		ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, White				
or ite	E.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 <del>☐ N</del> o	1	1 ∐Yes 2—LaTNo	Specify:	ritodri, etc.)	Specify:				
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n "nai	Completed	(Specify only highest grade completed)	(Give		during most of workii		Tallo of Business	madotty			
rthan	E O	Elementary/Secondary (0-12) College (1-4or 5+)	Unk	<b>.</b>			Railroad	l			
othe vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maid	en Surname)				
arked atic e	은	John Walter Banaskiewicz Sr.			Ethel	Gelieve Ph	illips	_			
is m		19a. Informant's Name/Relationship (Type. Print)				al Route Number, Cit	y or Town, State, .	Zip Code)			
om 27 ther t		Bernice Hutchins /Aunt  20a. Method of Disposition  20b. Pla		2 S. Betr sition (Name of	el St., M		Location - City or	Town State			
important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	netery, cřei	natory or other plac	e) :	Jan 13,	•	Le, Maryland			
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as th	sician/Medical	JE FENNIE.									
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rtifica tor, p	BeC	25. Was case referred to medical			26. Place of Death		NO TO TE	2   140			
his ce I direc	일	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   E	R/Outpatie	nt 3 □ DOA Oth	er: 4 ☐ Nursing Ho	me 5 Residence	6 □ Other (Spe	ecify)			
After t	ü	27. Manner of Death  1 ☑ Natural 5 □ Pending (Month, Day, Year)  28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	Wor	k?	28d. Describe how in	ijury occurred				
the f	icati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At hom	a farm st		Yes 2 □No	28f. Location (Street	and Number or P	ural Pauta Number			
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To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached		29a. Certifier 1 Certifying Physician: To the best of my knowl									
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To t	Ž	29b. Signalure and title of certifier	- A	29c. Licens	e number	29d.	Date signed (Mon	th, Day, Year)			
1		DAN SAMUR GAV	13by MARI	4) 80	1 C C C		1/6/10.				
10		30. Nowe and address of person who completed cause of death (Item 2	23a) (Type,	Print)	pm C	enerono	Lhar	rtal			
Sta	to.	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	70 /	1 Jurey	MIN UT	VIMUL	Jusp	. ( )			
Registr			back	1							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 0 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Schuare 6. Sex Roseda 19 If Under 1 Year | If Under 24 Hrs. HOSPITA 8. Date of Birth (Month, Day, 7/Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗆 F Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number d permit. Pages 1 and 2 should be filed within 72 hours after dean Department of Health and Mental Hygiene. Important: If item 27 is marked other them any injury or other trainer. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Brendel, 11. Marital Status 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 □Yes 2 No Specify. Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 3 Removal from State 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 110 Q 23a. Part 1. En the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on art failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Preumonia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of) Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) P.0. been signed by the should be detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð Completed 24a. Was an cate has t autopsy performed: The certificate l 1 □Yes Division of Vital Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

29b. Signature and title of certifier

Binh

31. Date filed (Month, Day,

30. Name and address of person who

Naunt

omplata

9000

DHMH 17 Rev 1/2001

**ORIGINAL** 

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐Ño

3. Time of Death

8:25 P

10d, Inside City Limits

1 □Yes 2 No

9. Birthplace (State or Foreign

Year

2010

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number NGUYEN, BINH

Franklin Square Drive, Baltimore MD

29d. Date signed (Month, Day, Year)

cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2010 Certificate of Death Day 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Α. BURKHARDT 2010 7:30p<sup>M</sup> <u>JANUARY</u> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Hours 1 □ M 2 🛛 I 86 218 12 3191 02/14/1923 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 28a-f show d other than "natural", or items 23a or 28a-f shov event, he Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE ROSEDALE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 7905 MONTROSE AVE 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 'natural", or i 1 ☐Yes 2 X No Specify: Specify: WHITE 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) DEPARTMENT STORE SALES is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental CHARLES CONWAY LENA BOSS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important: If item 27 Is ROBERT E. BURKHARDT/HUSBAND 7905 MONTROSE AVENUE BALTIMORE, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State HOLLÝ HILL 01/11/10 MIDDLE RIVER, MD injury ( 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Deepsee 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part 1. Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** wate disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner pertension Sequentially list conditions, if any, learning to himme liate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to or as a consequence of) Due to (or as a consequence of): Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 D Ectopic pregnancy 5 Other (specify) been signed by the should be detached 9 I I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Hospital or Attending 24 hours after death. 1 Watural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1b. ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Poppe Ki-31. Date filed (Month, Day, Year) 32. Begistrar's Signature

State Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			Sta	ite of Maryland / D			•	_	ibic.	
			1 - State Registrar		Certificate			Reg. No. 2	010	00315
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of D	eath Day	Year	3. Time of Death
-4	/Medic		Winfield Boyd Jr.				Januar			12:40 P M
	Examir	er	4a. Facility Name (If not institution, give street	and number)		vn, or Location of			ty of Death	
-	Funeral		568 Russell Avenue 5. Social Security Number 6. Sex	7. Age (In yrs. last birth	nday) If Under 1		4 Hrs   P Date of Bi	rth	gomer 9. Birthi	y place (State or Foreign
	Director		203-22-6105 IXXM 2		rs. Months D	ays Hours	Min.   (Month, D	ay, Year) 3/1929	Coul	PA
	pui 🔌		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Leastion				1.	Od Inside Otto Line
	Aaryla f sho	ō								0d. Inside City Limits 1 □Yes 2 No
	r 28a-	Director	MD Montgomer  10e. Street and Number	y Gait	hersburg	de		10g. Citizen of	What Cour	
	th with		568 Russell Avenue		2	0877			USA	
	rdear	Funeral	11 Marital Status 12. Wa	s Decedent Ever in U.S. ned Forces?			in? (Specify Yes or N Puerto Rican, etc.)	o- 14. Ra	ace - Americ	
36	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medicut Examiner nut by notified at	by F	14.54	Xfes 2 □ No es, Give ar or Dates:1952-53	1 □ Yes 2 <b>X</b> □		,	Speci	lfur.	
21215-0036	2 hour	per	15. Decedent's Education	16a. [	Decedent's Usual C	ccupation		16b. Kind of 8	Whi	
215	hin 7% e. an "na Medi	ple	(Specify only highest grade comp	leted) ( lege (1-4or 5+)	Give kind of work of life. DO NOT use r	lone during most e etired)	of working			,
7	ed wit ygien <b>ner th</b> :	Completed			urance A					nsurance
Maryland	I be filed v ental Hygie ed other t event, In	Be	17. Father's Name (First, Middle, Last)				's Name (First, Middle	e, Maiden Surna	me)	
Ž	should and Mer s marke umatic	은	Winfield Boyd, Sr.  19a. Informant's Name/Relationship (Type. Pri	nt) 195	Mailing Address (C		ta Weeter or Rural Route Numb	0:4 T	- 04-4- 7/-	0.40
			Anne B. Frampton/D				d, Sykesvi	-		•
re,			20a. Method of Disposition	20b. Place of I	Disposition (Name of crematory or other	of place)	Date	20c. Location		
<u><u>Ĕ</u></u>	Pages ment of ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	i ironi State	er Cemet		1/15/2010	Winfi	eld,	MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	9	Burrie	ddress of Facility	Funeral Ho			
	0.□ = # O		Lold Ke		1212 W	01d Li	berty Rd.,	Winfie	1d, M	D 21784
		8 8	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final	e on each line.		r dying, such as c	ardiac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Cardiac Disea Oue to (or as a consequence of						
1	Examiner			ac to (or as a consequence or	<i>y</i> .					
	pe ti	iner	cause. Enter Underlying	due to (or as a consequence of	):					
	ecute and I-trans	Examiner	that initiated events c.	lue to (or as a consequence of	١.					
90	e be e sician buria	calE		ac to (or as a consequence or	<i>)</i> .					
687	death certificate be executed e attending physician and d for use as the burial-transit		d							-
Box	th cert	Physician/Med	zoo. Trab dobbatin program	es, outcome of pregnancy	3 ☐ Ectopic preq			23d. Da	ate of delive	ery
о. В	e dear he att	sicis	1 Yes 2 No	Pregnant at time of death Unknown	5 ☐ Other (speci			M	onth	Day Year
<u>n</u>	that the de ned by the detached	Phy	9 ☐ Unknown 9 ☐ Part II. Other significant conditions contributing		bo undorluing coup	a given in Dest I	220 Did	tahasaa usa sas	steibusta ta ti	ne cause of death?
Records,	requires that been signed b	l by	Cerebrovascular D	-	ne underlying caus	e given in Part I.				ably 4 🗀 Unknown
		Completed	0020020100000202							
	ela has	duic					24a. Was auto perfe		prior to co- death?	psy findings available mpletion of cause of
	lcian: Th certificate ector, pag	a	25. Was case referred to medical			26 Place o	1 ☐ Yes	202No	1 ☐ Yes	2 □ No
	Physician: this certific al director,	TO B	examiner? 1 Yes XXNo Hospital	: 1  Inpatient 2 ER/Outp	oatient 3 DOA	Other	sing Home 5 🗷 Res		her (Specif	(v)
n of	iding Physician: th. : After this certifica : funeral director, p	Ë	27. Manner of Death  12™Natural 5 ☐ Pending	Date of Injury 28b. Tir (Month, Day, Year) Inju		Injury at Work?		how injury occu		
<u>s</u>	tor the	icati	2 Accident investigation	Discouling Advance (automate)		1⊡Yes 2⊡Ne				
Division	al or Attending P s after death. I Director: After i d in by the funers	Certification:	4 ☐ Homicide determined 286.	Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, off	ice	28f. Location (	Street and Num wn, State)	ber or Rura	I Route Number,
	B Hospital or 24 hours after E Funeral Directory filled in E		29a. Certifier 1 X Certifying Physician:	To the best of my knowledge,	death occurred at t	ne time, date and	place, and due to the	cause(s) and n	nanner as s	tated.
	To the Hospital or Ai within 24 hours after of To the Funeral Direc completely filled in by	Medical	(Check only 2 Medical Examiner: Or	the basis of examination and manner stated.	or investigation, in	my opinion, death	occurred at the time	date and place	and due to	the cause(s)
	To the within 2 To the comple	Ž	29b. Signature and title of certifier	P	29c. Li	cense number		29d. Date signe	ed (Month,	Day, Year)
			1 Dupt	D Other	DC	056345		1/11	/2010	
	VV		30. Name and address of person who complete							
	Sta	te	Piyush K. Patel, M.I 31. Date filed (Month, Day, Year)	34 Pagistrar's Signature		Wheator	1, MD 2090	6		
	Registra	•	JAN 1 2 2010	Edward A	all I					
DHI	/H 17 Rev 1/20	004	Unit a a cuit A	18	17.11					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2010 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Jan. 12 Day 2010 **Physician** 4:00 A. M Frances R. Bower /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Sykesville Transitions Health Care 8. Date of Birth (Month, Day, Year)
July 20,1930 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Mary land Hours 1 □ M 2 😾 F 215-26-1217 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b, County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventher must be notified at 1 ☐ Yes 2 ☐ No Carroll Westminster Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21157 1551 Bloom Road United States Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1∐Yes 2⊠No Specify: White Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home <u> Housewife</u> 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie M. Fowble Robert F. Gosnell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Westminster, MD 21157 1551 Bloom Road Thomas Bower Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Lake View Mem. Park Jan. 14,2010 Sykesville, MD 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory, PA of Funeral Service Licensee 23a. F rt1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hoc, or heart failure. List only one cause in each line. Sykesville. Approximate Interval Between Onset and Death Immediani Cause (Final Physician dise or condition resulting in death) /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence on law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the } as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed by the land of the land 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 1 Haknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed 1 ☐ Yes 2 ☐ N certificate 2 1 1 Tyes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: A propered filled in by the fu death. 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and -0054218

Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death, (Item 23a) (Type, Print)

OR Palmer, 18 Kanes Styllade, deit, Verter

Lancis

10-00168 Linda A. Biddison

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

inda A. Biddisor		I- For State	State	of Maryland		ment of icate of		Menta	ıl Hygien		No 201	n	00317
Physicia		Registrar 1. Decedent's Name (	(First, Middle,Las	t)						Reg. of Death		3.	Time of Death
Medical Examir		Linda	Anne Bio	ldison					Mont Janu	n D lary 6, 2	ay Year 010		1502 hrs
		4a. Facility Name (if r Howard Cour	not institution, giv	e street and number)		4	b. City, Town, or L Columbia	ocation of D	Death		4c. County of D Howard	eath	
Funeral Director	7	5. Social Security Nu			e (In yrs. last t		If Under 1 Year Months Days	If Under 2	Min			oreign	
Director	ļ	217-56-4		M 2X F	59	Yrs.			5	/11/1	.950	Country	y) MD
any	ŀ	Usual Residence of D 10a. State 10	Ob. County		10c. City, Tov	wn or Location	on					100	d. Inside City Limits
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th the Maryland 23a or 28a-f sho notified at once.			olly Qua	rter Rd.		140.14	210		0 / 0		USA	mariaan	Indian Pinel
hours after death with the Maryland natural, or items 23s or 28s-f sh Esaminer must be notified at once	Funeral Director	11. Marital Status  1 XXNever Married	1 2 Married	12. Was Decedent Armed Forces	>		Decedent of Hisp es, specify Cuban,				White, et		Indian, Black,
fter de		3 Widowed	4 Divorced	If Yes, Give Year	X No	1	Yes 2 X No	specify:			Specify: [	Whit	e
hours a	g b	15. Decedent's Edu	cation (Specify or	or Dates: nly highest grade con	npleted) 16		's Usual Occupations of working life.			e 16	6b. Kind of Busine	ess/Indu	stry
7 3 -1	Completed	Elementary/Secon	dary (0-12)	College (1-4 or	5+)				,		DI Inha	- II-	-1-1
5-0036 led within 72 tygiene. other than '	Ę.	17. Father's Name (F	irst, Middle, Last)	5+		201	tware	8.Mother's i	Name (First, M		PL Johns den Surname)	з по	pkins
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ID 212 2 should b and Men 27 is marl	2	19a. Informant's Nam	ne/Relationship (T	ype, Print )			Address (Street						
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Ore ges 1 a t of He t in its	-			Removal from St	ate cren	natory or oth	er place)						
	ł	4 Donation 5  21. Sign our of Fund	Other Specify: eral Service Licen		Cres	t Lawn	Mem. Ga ame and Address rier-Que	irdens of Facility	1/14/	201Q	Marrio	otts	ville, MD
Balti permit. Departi Import injury	-	Sam	un B (	auly		Bur	rier-Que	en Fu Libe	neral rtv Rd	Home Wi	& Cremai	tory MD	, P.A. 21784
Physician		23a. art I Enter the fail e. List only	disease, or comp	lications that caused ich line	the death. Do	not enter th	e mode of dying,	such as card	diac or respira	tory arrest	, shock, or heart	A	Between Onset and
Examiner	Ì	Immediate Cause (Fi				s of	chronic a	alcoho	ol abus	e		-1	Death
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876 tificate ng phy as the	<u>E</u>	IF FEMALE: 23b. Was decedent pi past 12 months?		23c. If yes, outcome 1 Live birth	me of pregnan		aldeath 3	Ectopic p	regnancy		23d. Date of dea Month	Day	Year
Box 68760, e death certificate be the attending physic ed for use as the bun	Physician/M		9 V Unknown	1 7	time of death	5 Oth	ner (Specify)						
D. B. it the de by the ached f	된	Part II. Other signific		3 Olikilowii	h but not resul	Iting in the u	nderlying cause gi	iven in Part	I. 23e	e. Did toba	cco use contribut	te to the	cause of death?
P.C		Hyperte	ensive a	theroscle	rotic c	ardio	vascular		1	Yes	2 No 3	Probabl	y 4 🗸 Unknown
ords,	lete	disease	e, breas	t cancer	(clinic	al hi	story),		248	a. Was an autopsy	prio	r to comp	sy findings available pletion of cause of
Division of Vital Records, P.O. ra lor Attending Physician: The law requires that the safter death.  "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaid.	Completed		-	ctive pul		-			1	performe Yes 2		th? Yes	2 No
tal Rection: The certificate ector, page	BeC	25. Was case referre examiner?	ed to medical				26.Place	Other -	heck only one				
f Vid	유	1 ✓ Yes 2 27. Manner of Death	No	lospital: 1 Inpation	ent 2 🗸 ER	UOutpatient  Time of Ir		y at Work?	Vursing Home		w injury occurred	Other:	<del> </del>
ion of tending Pheath.	Certification:	1X Natural	5 Pending	(Month, Day,)				es 2 N			,,		
VISIOI or Attender fer death director: in by the	fica	2 Accident 3 Suicide	Investigati 6 Could not	28e Place of Ir	njury - At home	e, farm, stree	t, factory, office be	uilding, etc.		cation (Stre Town, Stat		or Rural I	Route Number, City
Divisospital or A hours after meral Dire	Sel	4 Homicide	determine							TOWIT, Stat			
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the total page 2.	Medical			ian: To the best of m c:On the basis of exa									ause(s)
To To Com	Mea	29b. Signature and ti	tle of certifier	and manner stated			29c. License	e number	-	2	29d. Date signed	(Month,	Day, Year)
		Mh	Brassel	(AR)			O.C.N	M.E.			January 7, 20	010	
XV		30. Name and address					enn Street, B	altimore	MD 21201				
X V	ate	Melissa Bras	Day, Year)	ssistant Medica	i Examiner ar's Signatur	7. 4. 51		aitiiiiiie,	1VID 21201				
Regist	rar	31. Date filed (Month	N 1 2 201	O Dencer	43	par	Kar						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 11:14 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Augsburg Lutheran Home Locheran If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Pennsylvania Director <u>220-56-223:</u> Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** 1 Yes 2 X No Stevenson Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21153 USA Greenspring Valley Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2**x**☐ No f Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest and Mental Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) ReligiousSister Religion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည traumatic Burkardt Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heath as Important: If item 27 is any injury or other trau 1531 Greenspring Valley Road Stevenson, Md. 21153 Sr. Marian Schaechtel, SND deN Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ilchester Cemetery 1/15/2010 Ellicott City, Mr. permit. 21. Signature Fur I Service Licen 22. Name and Address of Facility 1050 York Road Ruck Towson Fureral Home, Inc. Towson Md. 21204 rart 1. Enter the disease, or complications the shock, or heart failure. List only one cause of ediate Couca ("") caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part 1. Enter the disease, or con Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Elter onderlying Cause (Disease or impury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for u in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Hospital 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2010 5:00  $A^{M}$ Charlotte Mahoney Beam January 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Greater Baltimore Medical Center 8. Date of Birth (Month, Day, Ye Nov. 27, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Min Year. 1 □ M 2 □ F Director 215-71-9958 5 2004 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylal Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evan in a result be notified at ONRE. 1 ☐ Yes 2 ☐ No Director MD Baltimore Phoenix 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 3524 Blenheim Road 21131 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 💢 No Specify Specify 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) dependent child 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Beam Hilarv Mahonev 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beam\_ Michael father 3524 Blenheim Road; Phoenix, MD 21131 1 ☑ Burial A ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other Specific 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Augustine's Cem. Silver Lake, PA 21. Signature 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Towson, MD 21204 Inc. 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one complicate the complex of Approximate Interval Between Onset and Death ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line Immediate Cause (Final disease or condition resulting in death) HYPOXIA **Physician** /Medical Due to (or as a consequence of) Examiner FNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed STREIFF SYNDROME HAUERMANbeen signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown 9 I Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, OF UELOPMEN TAZ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown this certificate has been all director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No INTRATHORAUC 24a. Was an autopsy 124PO TONIA 2 **ZN**io 1 ☐ Yes Hospital or Attending Physician: After this certification funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 □ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

21

State Registrar

DEPT 31. Date filed (Month, Day, Year) JAN 1 2 2010

GBMC

29b. Signature and title of certifier

04

PEDIATRICS OF 32. Registrar Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DLST31 PENTSLC

29c. License number

D0056303

5601 N CHARLES ST

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Burrs 2010 Mae Cascelia /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year 8. Date of Birth (Month, Day, Funeral Days Hours Min. 1 ☐ M 2 🔀 F 05/18/1939 70 213-34-2493 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Modical Examiner must be notified at 1X Yes 2 □ No Funeral Director N/A Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21217 U.S.A. 301 MCMechen Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No Specify: ģ 3 Widowed 4 Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland Public Television Elementary/Secondary (0-12) 9th Grade College (1-4or 5+) Custodian Department of Health and Mental Hygie Important: If item 27 is marked other t any injury or other traumatic event, in 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental Regina Webster ဂ္ George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2308 Mosher St., Baltimore, MD 21216 Chad C. Jones(Son) Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Louden PArk Cem. 01/15/10 Baltimore, MD 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home Mano 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (pisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and burial-tran Due to (or as a consequence of): attending physician Physician/Medical the as for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) □Yes 2□No P.O. the 9 Unknown detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown icate has been significate page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 21 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐ Yes Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred B Hospital or Attending Pl 24 hours after death. Funeral Director: After the After t 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □No the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified SVMAJ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar' Signature

10-00026 Jason Barber Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 3 2 1

		- For State C6	ertificate of De	eath	R	eg. No.	10 0002
Physician	1	Decedent's Name (First, Middle, Last)			2. Date of Dea Month	Day Year	3. Time of Death 0430 hrs
Medical Examine		Jason Maurice  4a. Facility Name (if not institution, give street and number)	I 4h C	Barber ity, Town, or Location of De	January 2	, 2010 4c. County of	
	Ì	5111 Levindale Avenue		altimore		N/A	
Funeral	5	5. Social Security Number 6. Sex 7. Age (In yrs.		Under 1 Year If Under 24		th (MM/DD/YYYY)	Birthplace (State or Foreign
Director		215-60-6666 <sup>1</sup> MM 2 F	56 Yrs. M	lonths Days Hours	Min. 08/2	4/1953	Country) MD
ú	_	Usual Residence of Decedent         10c. City           10a. State         10b. County           10c. City	y, Town or Location				10d. Inside City Limits
B 00 48			Baltimore	<u>,</u>			1 X Yes 2 No
Maryland 28a-f show any d at once.	Director	MD N/A E		. Zip Code	1	0g. Citizen of What	t Country?
ith the Maryland 23a or 28a-f sho notified at once	5	5111 LeVindale Road		21215		U.S.A	•
with ms 23	<u>a</u>	11. Marital Status 12. Was Decedent Ever in U		cedent of Hispanic Origin? pecify Cuban, Mexican, Pu		14. Race - White,	American Indian, Black, etc.
or ite	₹	1 Yes 2 X No		2 X No specify:	,	Specific	n l o ele
irs after ural", miner	a⊩	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)		sual Occupation (Give kind	of work done	Specify: 16b. Kind of Busin	Black ness/Industry
72 hours n "natur al Exam		Elementary/Secondary (0-12) College (1-4 or 5+)	<ul> <li>during most or</li> </ul>	f working life. DO NOT use	retired)		
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	6 years	El€	ectrician		H&S B	akery
		17. Father's Name (First, Middle, Last)	3 a -a b a -a		ame (First, Middle, I Turne)		
2121; suld be fil Mental H marked c event, p		Jason <u>E</u> 19a. Informant's Name/Relationship (Type, Print )	Barber 19b. Mailing Ado	Mary dress (Street and Number			State, Zip Code)
re, MD 2	1	Jacqueline Fletcher(Friend	3) 5111 L	eVindale R	d, Balt	imore,MI	21215
imore, MD 2121 Pages 1 and 2 should be fi ment of Health and Mental itant: If item 27 is marked or other traumatic event.	- [3	20a. Method of Disposition 20b	Place of Disposition crematory or other p	(Name of cemetery,	Date	20c. Location - C	City or Town, State
Pages Pages nent or ant: I	- 1	4 Donation 5 Other Specify: Al	nd Cremai	$torv = 10^{\circ}$	1/08/10	Baltim	nore,MD
Baltimore, permit. Pages l ar permit. Pages l ar Department of Hee Important: If ite injury or other tr	[	21. Signature of Funeral Service Licensee	22 Name JOS	and Address of Facility	vn Jr. E	uneral	Home re,MD 21217
Physician	1	23a. Part I. Enter the disease, or complications that caused the deat	th. Do not enter the m	0 N. Fultor ode of dying, such as cardia	ac or respiratory arr	est, shock, or heart	t Approximate Interval
fiviedical		failure. List only one cause on each line.  Immediate Cause (Final disease a Atherosclerotic Cardio	vascular Diseas	e			Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence					
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	of):				
		Course Enter Underlying Cause (Disease or injury that initiated	-6				
uted ransit		events resulting in death) Last Due to (or as a consequence d.	Oi).				
760, Corrected cate be executed physician and the burial - transit	Medical	UNPENDED AMENDED					
760, icate by physic the bur		IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth		eath 3 Ectopic pre	ananov	23d. Date of de Month	elivery Day Year
Box 687 e death certific the attending p	Physician/	past 12 months?  4 Pregnant at time of company and the past 12 months?	2 Fetal de	(Specify)	granoy	1.00	buy
Boy le deatl the att	S L	1 Yes 2 No 9 Unknown 9 Unknown			00 - D: 11	1	ute to the cause of death?
P.O.		Part II. Other significant conditions contributing to death but not Morbid Obesity, Diabetes Mellitus	resulting in the under	rlying cause given in Part I.			Probably 4 Unknown
ords, F	Completed by	Morbid Obesity, Diabetes Melitus					ere autopsy findings available
COFC	影					rmed? dea	or to completion of cause of ath?
Rec		25. Was case referred to medical		26 Place of Death (Cho		2 <b>✓</b> No 1	Yes 2 No
lis certi	ĭ	examiner? Hospital: 1 Inputiont 2	ER/Outpatient 3	- Inthat -	rsing Home 5	Residence 6	Other: Scene
vision of Vital Figure 1 or Attending Physician: free death. Director: After this certifin by the funeral director.	٥	27. Manner of Death 28a. Date of Injury	28b. Time of Injury	28c. Injury at Work?	28d. Describe	how injury occurred	d
ion tendir leath. for: A	<u></u>	1 V Natural 5 Pending 2 Accident Investigation		1 Yes 2 No			
Division of Vital Records, tal or Attending Physician: The law requirers after death.  Tal Director: After this certificate has been in the function to the function of the function of the function.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At	home, farm, street, far	ctory, office building, etc.	28f. Location ( or Town, \$		or Rural Route Number, City
Ospital ospital hours a uneral I		4 Homicide determined (Specify)  29a Certifier 1 Certifying Physician: To the best of my knowle	adan dooth accurred	at the time, date and place	and due to the caus	ea(s) and manner a	es stated
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the buring the completely filled in by the funeral director.		one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation,	in my opinion, death occurr	ed at the time, date	and place, and due	e to the cause(s)
F. 25 8	<b>≗</b>	29b. Signature and title of certifier	-	29c. License number			(Month, Day, Year)
		1) _ M _ IMD		O.C.M.E.		January 8, 2	2010
\	ľ	30 Name and address of person who completed cause of death (Ite Donna M. Vincenti, MD Assistant Medical Exa		enn Street, Baltimore	. MD 21201		
Sta	te	31. Date filed (Month 12 2010 32. Bigistrar's Signa					
Registr	ar	JAN 12 2010 Clown	P. Mars				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10e, perFH, G899, 1/14/2010
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helen P. Ballentine 2010 1:50 PM Januarv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Riderwood Village Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day March 2 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min 1 □ M 2 🕽 F Hours Country Michigan 91 Yrs. 213-38-0721 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits death with the Maryland Director must be notified 28a-f 1 ☐ Yes 2 No Maryland Silver Spring Montgomery 10a Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Funeral 23a <del>3142</del> Gracefield Road Rose Ct 1230 20904 **USA** 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black. White, etc. ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White 3 Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me any injury or other traumatic event, the Me ones. Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Alex Petrovich Sophia Melavich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol L. Ballentine, Daughter 10923 Montrose Avenue Box 191 Garrett Park, Maryland 20896 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/11/10 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ onar arters sease disease or condition Medical resulting in death) Due to (or as a consequence of) Éxaminer 110 Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examiner this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 400 1 Tes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 X Other (Specify) Hospital. Assisted 2 🗹 No ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27, Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death.
Funeral Director: After leted filled in by the funer (Month, Day, Year) 1 Natural 5 Pending injury work? 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Director completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 59524 2010 January 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 3110 GRACEFIELD ROAD SILVERSPRING, MD 20904 LOVEEN J. PUTHUMANA 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State

Registrar

JAN 1 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 00323 Beverly D. Baggett State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Beverly D. Baggett Medical Examiner 1300 hrs January 9, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital **Baltimore** NA 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24Hram. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Min. Director 53 03-09-56 214-62-8083 1 M 2 XF Country) MD Usual Residence of Decedent 10c. City, Town or Location ù 10a State 10b County 10d. Inside City Limits MD 1XX Yes 2 No 28a-f show NABaltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director s 23a or 28a-f e notified at o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 E. Preston Street Apt.#332 21202 USA Funeral 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. African 1 X Never Married 2 Yes 2 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year Specify: American ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) d other than ' Baltimore, MD 21215-0036 12th Grade 4yrs. Nurse Levindale N.H. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Benjamin B. Baggett, Sr. Evelyn N. Newton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code If item 27 is 108 N. Poppleton Street Baltimore, MD Ashanti Daniels-Daughter 20a. Method of Disposition

1 Burial 2 X Cremation 3 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Removal from State Metro Crematory 01-16-10 | Catonsville, MD 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 2121 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Approximate Interval Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical UNPENDED AMENDED attending physician or use as the burial The law requires that the death certificate be Records, P.O. Box 68760, IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year Day past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 ✔ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 ✔ Unknown Obesity; Chronic Alcohol Abuse Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 ✔ No death? 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Be Othera Nursing Home 5 Residence 6 Other 1 Inpatient 2 V ER/Outpatient 3 DOA 1 V Yes No 28a. Date of Injury (Month, Day,Year 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No Director: 1 in by the f 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide 6 Could not be or Town, State) determined Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical the 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 11, 2010 30. Name and address of person who completed cause of death (Item 23a) Rüssell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Yea

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

**ORIGINAL** 

DC ME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ Month 4 200M Medical anuai24 Eacility Name (if not institution, give street and number) Examiner 4c. County of Death Samaritan If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2-6-1957 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 214-64-4884 52 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits n/a Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1421 Montpelier Street 21218 USA er than "natural", or items the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
African-American þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: Completed 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry سنامنی مسلمانی مسلمانی مسلمانی مسلمانی مسلمانی بردی این استخواط در استخواط در استخواط این Elementary/Seconday (0-12) College (1-4 or 5+) ER Tech St. Joseph Medical Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be fill Health and Mental James Mack Buckson Delores Hall 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 4405 Moravia Road, Apt. 2, Baltimore, M) 21200 Tia M. Buckson/ Daughter Health tem 27 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith Page 1 permit. Page 1
Department of I
Important: If it
any injury or o: Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1-11-10 WhiteMarsh, MD 22. Name and Address of Facility Wilte Funcial Home F.A. of Baltinure Co. 9200 Liberty Road, Randallstown, MD 21133 of Funeral Service Licenses 2 Signature Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause in each line? Approximate Interval Between Immediate Cause (Final disease or condition Physician, Onset and Death Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine as a consequence of: signed by the attending physician and de detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown peen a 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has I autopsy performed? Yes 2 No After this certificate 2 🗆 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 🗌 Yes 2 No 1 🕽 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? ☐ Accident Investigation 2 | No 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie The Certifying Newsee Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Newsee Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signa d title of ce 29c. License number 29d. Date signed (Month, Day, Year) D63382 5 lanuary 30. Name and address of person to completed Palse of death (Item 23a) (Type, Print) 5601 Loch Raven Blud Baltimore MD 2123

Registrar
DHMH 17 Rev 7/2009

State

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Z Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** JANUARY 9, 2010 4:56 A M TERRY ANN BURNETT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 8, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours Min 1 □ M 2X F 216-74-8940 49 1961 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō USA items 23a 3 Oakdale Ave. 21001 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or If Yes, Give Year or Dates: 1 ☐Yes 2 XNo Specify. þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withii Health and Mental Hygiene. em **27 is marked other than** 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sidnev Eugene Long Patsy Carolyn Gilliam ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 3 Oakdale Ave., Aberdeen, Maryland 21001 Thomas M. Burnett / Son Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. George's Epis. Cem. 1-13-10 Perryman, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a, Part 1 Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami burial-trar Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 20 No **Division of Vital** 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No Medical Certification; To 1 🔲 Inpatient 2 ER/Outpatient 3 DCA After this filled ir by the funera 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No affer death Director: 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Mgnth, Day, Year) Kandos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 16b per in 8899 1-12-10 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Z 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) POM Vear Month 444 **Physician** Vonzella Barksdale 2010 /Medical 4c. County of Death Facility Name (If not institution, give street and pumber) 4b. City, Town, or Location of Death Examiner osedale DaLtimore ware Hospital (enter If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Min. | Mar. 18, 1946 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 □ M 2 □ F Maryland 63 217 46 2208 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is Medical Extrained must be notified. MD Baltimore Essex X☐Yes 2☐No Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 811 Brunswick Rd. Apt. 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: SpecifyBlack þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Roya1 Elementary/Secondary (0-12) College (1-4or 5+) 10th Cashier Royal Farms 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter C. Bell Jessie Thorton ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kaiwana Astew (daughter) Brunswick Rd. Apt.2A Essex, Md. 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Jan.14.2010 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Green Mount Crematory Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licenses Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto,Md. 21213 23a. Part 1. Enter the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic Obstructive **Physician** ulmonary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or is a consequence of): Examiner executed burial-transi Kidney nronic and Due to (or as a consequence of): physician Box 68760 law requires that the death certificate be Physician/Medical the as . attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) signed by the a P.0. 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate | 2 No 1 HYes Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Hospital or Attending 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and mapmer stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square -eus ierre 000 31. Date filed (Month State

DHMH 17 Rev 1/2001

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Division of Vital Records, P.O. Box 68760	ital or Attending Physician: The law requires that the death certificate be executed after death.	rai Director. After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial-transit	

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ician.	/	1. Decedent's Name Bernard		L.	Bric	e				- 1	2. Date of Dea Month JANUA	Day	y <b>3.</b> 1	Year	3. Time of Death 7:13 A
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eral tor	k	5. Social Security Nu 2 1 8 – 4 4 – 4	363	6. Sex 1 🖾 M 2 □	7. Age (Ir	In yrs. last birthda 6¥4°	Months	n 1 Year Days	If Under 2 Hours	Min	8. Date of Birt (Month, Day Feb 7				olace (State or Foreig atry) MD
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	Iola Brice Hill/ Sister   5404 Bucknell Rd Balto. Md 21  20a. Method of Disposition  1  Burial 2  Removal from State												own, State		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) o<sup>Day</sup> Year **Physician** 00 PM 2010 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Hore Rockeda to mare If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 M 2 4 195-38-Director 10 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MI 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2124 3402 by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ Mo Specify Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ other traumatic . Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) McCollugh 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit, Pages Department of Important: If Its any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro 4 ☐ Donation → 5 ☐ Other (Specify) 21. Signatur of uneral Service Licen. NO21251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Literine Physician disease or condition resulting in death) year /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate eause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physlcian: The law requires that the death certificate be executed burial-trag Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physiciar the cate has been signed by the attending page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 3 Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? autopsy After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation s after death.

Il Director; Ai
ed in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

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completely filled filled 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D43934 MOJANUARY 12,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21202 IM MI) 227 PAUL BALTIMORE 81. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Reg. No 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Cecelia Stewart Chandler 11 Jan. 7:20 P. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Broadmead Retirement Community 7. Age (In 7rs. last birthday) Cockeysville Baltimore County If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min 1 □ M 2 □XF Months 94 Yrs Sept. 22, 1915 212-01-1608 Baltimore, MD. Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 X No Maryland Baltimore County Cockeysville 10e. Street and Number 10g. Citizen of What Country? 13801 York Road 21030 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ▼No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 01 Own Home Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Warren A. Stewart Marguerite V. Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Warren Stewart Chandler(son) 11921 Falls Road Cockeysville, MD. 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan.13, 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Evans Funeral Chapel 4 Donation 5 Dother (Specify) 2010 Forest Hill, Maryland Peaceful Alternatives Funeral&Cremation Ctr., P.A. 21. Signature of Funeral Service Licenses Pit1 Ether the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or he fit failure. List only one be use on each line. 2325 York Road Timonium, Maryland 21093 Approximate Interval Between Onset and Death Immediate Cause (Final ALZHEMERS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) peripheral that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 **2** No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 □ Could not be 3 ☐ Suicide

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4 ☐ Homicide

29a. Certifier

aw requires that the death certificate or Attending Physician: The Vital ō Division uneral Director: A ely filled in by the fu

To the Hospital within 24 hours a To the Funeral C completely filled

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Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

determined

and manner stated.

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

YORK RD EOLKEYSVILLE, MD 21030

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROSE SADIE CARLINO JANUARY 2010 8:25P Medical 4a. Facility Name (if not institution, give street and number)
PICKERSGILL RETIREMENT COMUNITY 4b. City, Town, or Location of Death Examiner 4c. County of Death TOWSON BALTIMORE . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Min. 6-23-1920 Months Hours 085-07-4619 1 🗆 M 2 🖳 F 89 Yrs. NEW YORK Director Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location with the Maryland Director MD GARRETT OAKLAND 1 🗆 Yes 2 🔀 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 36 HERRINGTON HEIGHTS DRIVE 21550 U.S.A. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X☐ No Specify: WHITE Specify: 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working within 72 al Hygiene. ST. LEO's CHURCH/ life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) COOK ST. CLEMENT CHURCH permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked oth any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ LEO FRANCHAPANI ANTOINETTE (SCUFONO) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21550 GIUSTO CARLINO/SON 36 HERRINGTON HEIGHTS DR. OAKLAND, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗋 Removal from State 4 Donation 5 Other (Specify) GARDENS OF FAITH 1-11-10 BALTIMORE 21. Signature of Funeral Service In 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 21237 CHESACO AVE ROSEDALE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 D No b Month Day ate has been signed by the page 2 should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate 2 🗌 No 1 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) 2 **X** No Hospital: Other: မ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No after death. Accident Investigation M 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I only one) 29b. Signature and tille of certi 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) ic Bushmi) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 00331 State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 10, 2010 10:50P M Lillian Marcella Creswell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kingsville 7146 New Cut Road Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Aug 16, 1925 1 □ M 2 🗓 F Days Hours Maryland 213-20-3153 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is amarked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Kingsville Maryland Baltimore 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21087 USA 7146 New Cut Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Department Store Cosmetic Sales Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel Mast Elmer L. Clayton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7146 New Cut Road Kingsville, Maryland 21087 Lillian E. Deeble, Niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 01/11/10 Baltimore, Maryland Signature of Funeral Service Licenge Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryl Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ontet and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): . Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine that the death certificate be executed for use as the burial-tran and that initiated events resulting in death) Last as a consequence of): attending physician Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ hydro uphalis 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of mellitis type autopsv perform 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be

To the Hospital or Attending Physician: The law requires Division of Vital Records, s certificate has be lirector, page 2 s director, this within 24 hours after death.

To the Funeral Director: After thi
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examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural iniury 5  $\square$  Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c, License number

615 West Marphiel Rd Bel Air MO 21014

29d. Date signed (Month, Day, Year)

(1)

State Registrar

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Certificate:

Medical

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29b. Signature and title of certifier

rson who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] 00332 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 George W. Conley Jan. 11:35 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Oct. T 1 X M 2 - F Months Days Hours 1933 Director 212-30-2596 76 Usual Residence of Decedent ural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1 Yes 2 No Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 10525 Gateridge Rd. 21030 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 X Yes 21215-0036 white 1 Tes 2 XNo Specify: Specify 3 Widowed 4 Divorced Completed Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natu ury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) National Representive Plumbing Supplies Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Perry Conley Elizabeth Virginia Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Perry L. Conley/brother 1717 Greenspring Dr., Lutherville, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Dulaney Valley Memorial Gardens Timonium, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Funeral San Michael J. Hagie 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Due to (or as a consequence of) disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last death certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hospital or Attending Physician: The law requires Records, Completed MODOR OLSEN 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed?

Yes 2 No 1 Yes 2 No Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 No 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA this ð the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident
3 Suicide Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed (Check The desired at Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 5356 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 2 2010 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 0333

Certificate of Death

		Registrar Certificate (	of Death		F	Reg. No.						
Physici edical Exami		Decedent's Name (First, Middle, Last)     Mildred Ida Covell			Date of Dea Month January 8	Day	Year	3. Time of Death 1215 hrs				
		4a. Facility Name (if not institution, give street and number)  Gilchrist Center	4b. City, Town, or Location of Towson	of Death			county of Death					
Funeral Director		troused taxania	If Under 1 Year If Under Months Days Hours		B. Date of B		9. Bir 24 Per	rthplace (State or Foreigr ountry) NNSylvania				
and show any nce.	ō	Usual Residence of Decedent  10a. State  10b. County  Maryland  N/A  Baltimore						10d. Inside City Limits 1XX Yes 2 No				
the Maryl sa or 28a-f stiffed at o	Director	10e. Street and Number 3025 Keswick Road	10f. Zip Code 21211			10g. Citizer	n of What Cou USA	ntry?				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland pepmirm. Pages I and 2 should be filed within 72 hours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? If Yes 2 XX No	/as Decedent of Hispanic Orig Yes, specify Cuban, Mexican,				White, etc.	ican Indian, Black,				
2 hours afte "natural" Examine	ted by	15. Decedent's Education (Specify only highest grade completed) 16a. Decede	1 Yes 2 X No specify: Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				d of Business/					
-0036 d within 7. rgiene. ther than	Completed	6 Mac  17. Father's Name (First, Middle, Last)	stic Ma	anufacturing								
1215 Id be file fental H narked o	o Be (	John Miller  19a. Informant's Name/Relationship (Type, Print ) 19b. Maili										
MD 2 nd 2 shou alth and N m 27 is n aumatic	ř	William Covell Son 3025 Keswick Road, Baltimore, Maryland 21										
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Insportant: If tiem 27 is marked other than injury or other traumatic event, the Medical		1 X Burial 2 Cremation 3 Removal from State Lake Vie	Town State e, Maryland									
Bal permit Depar Impor		Turm B. Henss	Name and Address of Facility Surgee-Henss-S 631 Falls Road	eitz l	Funera ltimo	al Ho	me, Ind	g. 21211				
Physician /Medical Examiner		23a. Part I. The the disease, or complications that caused the death. Do not enter failure: List only one cause on each line. Immediate Cause (Final disease a. Hypertensive cardio)	the mode of dying, such as ca vascular disea	ardiac or res	spiratory ar	rest, shock,	, or heart	Approximate Interval Between Onset and Death				
	er	or condition resulting in death)  Due to (or as a consequence of hip fi  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	acture ——————									
ed nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):										
3760, ficate be executed g physician and s the burial - transit	n/Medical	AMENDED 23a,PII,27,28a-	-f.permE. 0901	3/22	/10 T	т						
'60 ate b	ĕ.	IF FEMALE: 23c. If yes, outcome of pregnancy	r,permi, goor	3/22	, 10 1	23d. D	Date of deliver					
Division of Vital Records, P.O. Box 68760, To the Hospital or therificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/	Progrant at time of death	etal death 3 Ectopic other (Specify)	pregnancy				Day Year				
, P.O. Fres that the signed by the be detached	ξ	Part II. Other significant conditions contributing to death but not resulting in the  Dementia, diverticulosis, atrial fi	, ,	rt I.				the cause of death?				
Vital Records, P.O. Box 68: hysician: The law requires that the death certificate has been signed by the attending I director, page 2 should be detached for use as I	ompleted				24a. Was autop perfo	psy orm <u>ed</u> ?		utopsy findings available completion of cause of				
al R	၁	25. Was case referred to medical	26.Place of Death (	Check only		Local Control	المكادا	locard .				
Vita	O B	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatier	ot 3 DOA Other	Nursing H	ome 5	Residence	e 6 🗸 Other	r: Scene				
on of lending Pl eath or: After the funeral	tion: T	27. Manner of Death  1 Natural 5 Pending Investigation Ptd 1/8/10 Fd 121	1 Von 2 ▼		Describe							
Division of To the Hospital or Attending Phwithin 24 hours after death To the Funeral Director: After I completely filled in by the funeral	280. Date of Injury 280. Time of Injury 280. Time of Injury 280. Each pending Investigation 2 X Accident 2 X Accident 3 Suicide 6 Could not be determined 8. Suicide 6 Could not be determined 8. Specify Gilchrist hospital 280. Date of Injury 280. Time of Injury 280. Time of Injury 280. Time of Injury 280. Date of Injury 280.											
Fo the Hos within 24 h Fo the Fust completely	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occu (Chack only one)  2 Medical Examiner: On the basis of examination and/or investigation and manner stated.										
	Σ	29b. signature and title of certifier	29c. License number O.C.M.E.				e signed <i>(Moi</i>	nth, Day,Year)				
81			nn Street, Baltimore, M	/ID 21201	ı							
St Regist	ate trar	31. Date filed (Month, Day, Year)  JAN 1 2 2010  3. Registrar's Signature	res .									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, per Inf G899 1/21/10 TT
State of Maryland/Department of Health and Mental Hygiene 00334 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** ornish 23 05 DM 2010 Tanuary /Medical City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hospital orthwest Kardallstown Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 218-48-6355 1 🔀 M 2 🗆 F 61 Yrs 03/19/1948 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination ust be notified at once. 1 X Yes 2 ☐ No BALTIMORE MD BALTIMORE Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21244 3805 CORONADO CIRCLE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∐Yes 2 TXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 No Specify BLACK Specify: \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BALTO. SCHOOL SYSTEM SPECIAL ED. TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ CELIA MAE YOUNG HERBERT CORNISH, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3805 CORONADO CIR., BALTO., MD 21244 JOCKOLETTE CORNISH/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/19/2010 LAUREL, MD MD. NAT. MEM PK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licensee 1701 LAURENS ST., BALTIMORE, MD 21217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumoma Lays **Physician** disease or condition resulting in death) /Medical Due (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ diabe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 15 A¥es 2 □ No 1⊋Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: , 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1Secrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1)00 6874 Attending, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randallstown Maryland 21133 Old Court Road Adegiga, 540 Oladunni 31. Date filed (Month, Day, 32. Registrar's Signature JAN 1 2 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20a-c State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear **Physician** Month 5, 2010 Catherine Conners January 9:04 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 305 E. Joppa Road #507 Towson Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral Months 1 □ M 2 🔽 F 80 Director 215-32-5249 June 6, 1929 Maryland Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a. State show other traumatic event, the Medical Exeminer must be notified at Director Baltimore 1 ☐ Yes 2√☐ No Towson 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 305 E. Joppa Road #507 21204 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ∐Yes 2 X No Specify: White Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) registered nurse 12 healthcare is marked other unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is 1
any injury or other trau Mary Buechler/friend 225 Willow Avenue Towson, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 Mother (Spec)(y) Evans Funeral Chapel 1/25/2010 Forest Hill, MD 22. Name and Address of Facility Peaceful Alternatives 16924 York Road 21. Signature of Euneral Service Licensee Ronald S. Wa State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Timonium, MD 21093 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1 shock. Immediate Ca — inal disease or condition resulting in death) **Physician** Artonio scleratic Candiovascular /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-tran Due to (or as a consequence of): Box 68760, The law requires that the death certificate be Physician/Medical as attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 🗆 Live birth 2 🗀 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Day Year Pregnant at time of death 5 Other (specify) P.0. 9 T Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed; certificate | 2 No 1 ∐ Yes 2 1 No 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 【Residence 6 ☐ Other (Specify) Hospital: 1∭XYes 2∐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation n 24 hours after death.

e Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier TO T 29c. License number 29d. Date signed (Month, Day, Year) 5,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ill CT Lutherville, MD 6 Trimb Phil. M: M 4 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 2 2010 Registrar

2010

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Conners

atherine

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Margaret de Ropp Du Vivier :58 P. January 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Examiner Cockeysville Broadmead Retirement Center 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Ios Angeles California 7. Age (In vrs. last birthday 8. Date of Birth Funeral Month, Day, Year)

Jov. 5 <u>1920</u> Days 1 D M 2 1 F 89 Director 055-38-2834 ral", or items 23a or 28a-f shov Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Cockeysville Direct Maryland 1 ☐ Yes 2 X No 10e. Street and Numbe 10f, Zip Code 10g Citizen of What Country? United States Funeral 21030 13801 York Road of America 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. "natural", or 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give ģ Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 I and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Diplomat's wife Foreign Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important. If item 27 is marked any injury or other traumatic ev 2 Margaret Trimble Harald de Ropp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne K. Du Vivier/ daughter 2940 Wilton Avenue Silver Spring, Maryland 20910 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January 11 cemetery, crematory or other place) 1 ☐ Burial 2 🛭 Cremation 3 ☐ Removal from State Evans Funeral Chapel Forest Hill, Maryland 4 Donation 5 Other (Specify) 2010 21. Signature of Fundal Service Licens Peaceful Alteratives Funeral & Cremation Center, P. 2325 York Roal Bakimore, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Que to (or as a lons quence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the buniaf-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Day Year 1 Yes 2 9 Unknown ed by the a detached f n signed by t Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24a. Was an Were autopsy findings available prior to completion of cause of has autonsy death? certificate Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital Other: 2 1 No မှ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending L Natural 5 Pending injury 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined within 24 hours a

To the Funeral L Medical 29a. Certifie 🖫 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 30. Name and address on who completed cause of death (Item 23a) (Type, Print State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Di Venti Jamuary Angeline Μ. Pay 20°110 5:45 ам Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Oak Crest Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min. May 1, Day, 1922 Marviand Director 214-16-5643 87 Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must <u>be notified at</u> 10b. County Director 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits 1 Yes 2 X No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8800 Walther Blvd. 21234 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🗶 No 1 Yes 2 No Specify: If Yes, Give Specify:White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Angelo Francesca Monico Rizzo permit. Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Frank DiVenti, Jr./ 6310 Birchwood Ave. Baltimore, Md. 21214 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gardens Of Faith Cem. 1-15-10 Baltimore, 21. Signature of Funeral Se 22. Name Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. ice Lia nsee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final UNG Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Ducito for es e consequence on been signed by the attending physician and should be detached for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 menths?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Records, 1 🗌 Yes 2 🗌 No 3 Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been six completed filled in by the funeral director, page 2 should the supplies of the funeral director, page 2 should the supplies of the funeral director, page 2 should the supplies of the funeral director, page 2 should the supplies of the funeral director, page 2 should the supplies of 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) PRACATTIONER Medical Certifying Physician: 10 the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and WALTHER BIVE

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

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			For State Registrar		State of M	aryıaı			ent of F ete of L		ina ivie		gien <sub>Reg. N</sub>	2010		00338
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	Examin		4a. Facility Name (if not i	institution, give	e street and number)			4b. Cit	y, Town, or	Location of				c. County of Deat		
	<i></i>		Stella M			,,		140-4		Towson				Balt		
	Funeral Director		5. Social Security Number 218-78-777		Sex 7. Ag I□M 2 🔀 F		ast birthday) Yrs.	Months	der 1 Year s Days	If Under 2 Hours	Min.	B. Date of Bird (Month, Da ECEMBE	th y, Year) r 5	9. Bir Co 1957	untry	e (State or Foreign yland
	nd tr	١	Usual Residence of Dec. 10a. State 10b	edent c. County		10c. Cit	y, Town or Lo	cation								Inside City Limits
	Marylar 28a-f sk	Funeral Director	Md.	Bal	timore		,,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Dunda	alk						1 ☐ Yes 2X No
	n with the is 23a or	neral [	10e. Street and Number 7520 Sc	chool A	ve.			10f. 2	Zip Code	21222			10g. C	itizen of What Co USA	ountry?	1
11:15 a.m. 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>3 ☐ Widowed 4 ☐</li></ul>		12. Was Decedent I Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.			If Yes, sp	ecify Cuba	ispanic Origi In, Mexican, Specify:	in? (Specif Puerto Ric	y Yes or No- can, etc.)	No- Black, White, e Specify: Whit			ndian,
1:1	"natu edical	Completed		. Decedent's E only highest gr	Education rade completed)		16a. Dece (Give	kind of w	ork done c	ation during most o	of working		16b. l	Kind of Business	Industr	ry
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	l be filed w lental Hygi rked other tic event, i	To Be	17. Father's Name (First,		miller		1			18. Mother		First, Middle,				
, 2 <sup>1</sup>	2 should Ith and Ma 27 is mar traumati		19a. Informant's Name/I		Type, Print)			-					. ,	r Town, State, Zij	o Code	)
e, ≥	and 2 Health em 27 ther tr		John Dye  20a. Method of Dispositi		Husband		Place of Dispo			ol Ave				21222		
JANUARY 8, 2010 Baltimore, Maryland	Page 1 ment of I tant: If it			remation 3	Removal from State		cemetery, crei k Lawn	natory or	r other plac		Janua 12, 2	ry		ocation - City or Sundalk ,		
JAN	permit. Departn Importa any inju		21. Sonature of June al	Service Licen	see Conn	elli	<i>y</i> 2:	Con:	and Addres	Fune:	ral H	Iome Of	E Du	ndalk,P.	.A.	21222
3	Ph_sician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition MIII.TTPLE SCLEROSTS													proximate erval Between
	) Medical Examiner		resulting in death)  MULTIPLE SCLEROSTS  Due to (or as a consequence of):													
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260	cate be physicial the bur	edical		•	d											
1 DYE P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the b	by Physician/Medio	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 X No 9 ☐ Unknown		23c. If yes, outcome  1  Live Birth 4  Pregnant a 9  Unknown	2 ☐ Feta	aJdeath 3 L		c pregnanc (specify)	y				23d. Date of del Month	livery Day	Year
	requires that the de been signed by the should be detached	d by P	Part II. Other significan	t conditions o	contributing to death b	out not res	sulting in the u	ınderlying	g cause giv	ren in Part I.		23e. Did to		use contribute to		use of death?
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α.	ician: The law certificate has rector, page 2 s						•					1 🗆 Yes	rmed?	death? lo 1 ☐ Yes	2 🗆	No
ita	sician: certific irector,	Be c	25. Was case referred to examiner? 1 ☐ Yes 2 X No		Hospital:				Otho	ace of Death er:	, , , , ,	2 2 2 7		_		OGDT GE
οf V	y Phys er this eral dii	e: To	27. Manner of Death		28a. Date of inju	rv	ER/Outpatie		28c. Injury	4 ⊔ Nurs ≀at		e 5 ∐ Resid d. Describe h		6 X Other (Spec	ify) H	OSPICE
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Division of Vital	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completed filled in by the funer	al Certificate:										ral Rou	te Number,			
10	ne Hospi in 24 hou ne Funer pleted fil	Medical									e and due to the o	ause/s	) and manner stated.			
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-			30. Name and address of	of person who	completed cause of d	eath (Item	n 23a) (Type, I	Print)	<del>1)</del> '	44	-			40/00		
(1)			JACKTE JON	ES. CR	NP 2300 D	ULAN	EY VAL		RD.	TIMON	IUM,	MD 210	093			
SERVE	Stat Registra	e ir	81. Date filed (Month, Da	AN12	2010 32. Reg stra	ar's Signa	ture A.	back	La P							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		,	Cei	tificate of	Death	R	eg. No. 20	10	0033	9
	Dhysisi		1. Decedent's Name (First, Middle,	Last)					2. Date of Dear	h Dav	Year	3. Time of Death	
_	Physicia /Medic		John	Da	amico	)			Januar	y 11,2	2010	10:58&	_
1	Examin	er	4a. Facility Name (If not institution, § 308 S. Exeter				4b. City, Town, o Baltim	r Location of Deat ore	th	4c. County	of Death		
ı	Funeral Director				6 (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year)	9. Birthpl Coun Mary	ace (State or Foreign try) Land	7
	w w		Usual Residence of Decedent  10a. State 10b. County		10c. Citv.	Town or Lo	cation				10	Od. Inside City Limits	
	/aryla	JO.	Md			timo						1 X Yes 2 ☐ No	
	the N	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of V	, Citizen of What Country?		
	h with	al D	308 S. Exete	r Street			2120	2		USA			
36	be filed within 72 hours after death with the Maryland tal Hygiene. And Hygiene.  do other than "natural", or items 23a or 28a-f show event, it is Modical Eron item.	by Funeral	11. Marital Status  1 ▼Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces?			Was Decedent of H f Yes, specify Cuba 1 □ Yes 2 🕱 No	Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		e - Americ k, White, e		
ğ	2 hou atura cal E	ted	15. Decedent's	Education		16a. Dece	dent's Usual Occup	pation	atila a	16b. Kind of Bu	isiness/Inc	lustry	
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21	e filed within al Hygiene. other than " vent, in a Ma	S	12th				Clerk	10 Methor's No	me (First, Middle,				
=		o Be	17. Father's Name (First, Middle, La Salvatore Dai						oria Con				
Ĭ.	should be and Menta s marked umatic ev	은	19a. Informant's Name/Relationship	p (Type. Print) brot	ther	19b. Mailir	ng Address (Street	and Number or R	lural Route Numbe	r, City or Town,	State, Zip	Code)	_
Ĕ	and 2 s lealth ar m 27 is her trau		Rudolph Leona:	rdi		7382	Norris	Ave. S	Sykesvil			and21784	
ore	of H fite		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3	S ☐ Removal from State		-	sition (Name of matory or other pla	ce)	Date	20c. Location - Baltimo	,		
Ĕ	Pages tment of tant: If It jury or o		4 ☐ Donation 5 ☐ Other (Spe	ecify)	New		hedral	1	7/2010				_
Ba	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Li	censee	*	22	63 S. C	onkling	oseph N. g St.Bal	Zann: timore	ino (	Jr.FH D 21224	
			23a. Part 1. Enter the disease or conshock, or heart failure. List or	omplications that caused	I the death.	Do not ent	er the mode of dyi	ng, such as cardia	ac or respiratory ar	rest,		Approximate Interval Between	
No.	Physician	ë 9	Immediate Cause (Final disease or condition	a.	•	Ý	tento	Range	FALL	14		Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):	Dx . N4	(14,01	1 4				
		er	Sequentially list conditions,				_						
	outed d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
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68760	ficate be executed physician and s the burial-transit	Medical		d									
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<u>a</u>	slcian: The certificate h rector, page	ပ္ပ	25. Was case referred to medical					26 Place of De	1 □ Yes eath (Check only o	2 No	1 □ Yes	2 □No	
>	Physicia this cert al direct	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 🗆 E	R/Outpatie	nt 3 DOA Oth	ner: 4 🗆 Nursing		lence 6 Oth	ner (Specif	'y)	_
n 0	Attending Physician: It death. ector: After this certifica by the funeral director, i	T:uc	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ıry 2 ıy, Year)	28b. Time o Injury	f 28c. inju	ry at rk?	28d. Describe h	ow injury occur	red	<del></del>	
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Division of Vital Records,	after d after d Direct d in by	Certification:	4 ☐ Homicide determin	20e. Flace of Inju	ury - At hom c. <i>(Specify)</i>	ne, farm, sti	reet, factory, office		City or Tow	n, State)	er or Hura	al Route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C		Physician: To the best xaminer: On the basis of and manner sta	of examination								
V	To the vithin To the comple	Mec	29b. Signature and title of certifier	and mainer st	u.ou.		29c. Licen	se number		29d. Date signe	d (Month,	Day, Year)	_
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			a0. Name and address of person w	ho completed cause of c	leath (Item :	23a) (Type,	Print)	-					
			Juna Sali	32. Registr	101	The	on st		513	124			
	Sta Registi		31. Date filed (Month, Day, Year)		ar s algnati	box	1						

			For State Registrar		Maryland / Dep <i>Ce</i>		of Health of Death			iene <sub>eg. No.</sub> 20	10	00340
	Physici	an	1. Decedent's Name (First, Middle,	Last)					2. Date of Deat Month	h Day	Year	3. Time of Death
	/Medi		JUANITA		DONALD				Januar	y 8, 2	010	15:00 M
,	Examir	ner	4a. Facility Name (If not institution,			4b. City, To	own, or Location	of Death		4c. County of		
			Greater Baltimor  5. Social Security Number 6		Center Age (In yrs. last birthday)	To	WSON Year   If Under	r 24 Hrs	9 Data of Birth		imor	
	Funeral Director		212-30-0847	1□M 2□F	78 Yrs.		Days Hours	Min.	8. Date of Birth (Month, Day,		Counti	ace (State or Foreign ry) MD
	D		Usual Residence of Decedent						04/28/19	231		1113
	show	_	10a. State 10b. County		10c. City, Town or Lo	ocation					10	d. Inside City Limits
	Ba-f	Director		imore	Baltimor	e						1 ☐ Yes 2 ☐ No
	with th		10e. Street and Number			10f. Zip C			11	Dg. Citizen of W	nat Countr	ry?
	eath Is 23	Funeral	202 Virginia A	venue 12. Was Decede	ent Ever in II S 12	2122		sigin 2 /Cons	eif: Ve e en Ne	14 Dans	A	n Indian
(0	fter d r iten	Fun	1 ☐ Never Married 2 ☐ Marrie	Armed Force	es?	If Yes, specif	nt of Hispanic Or y Cuban, Mexica	n, Puerto F	Rican, etc.)		- America , White, et	
036	urs a	þ	3 ☐ Widowed 4 🎇 Divorced	If Yes, Give Year or Date	_	1 □ Yes 2 <b>3</b>	No Specify.	:		Specify:	Whi	ite
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and	l be fintal bed of	Be		SI)						laiden Surname	,	
Z	hould id Me mark mark	ို	Willie Wright  19a. Informant's Name/Relationship	(Time Print)	10h 14a0	A				Wright		2 ( )
Baltimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, If a No Xew Evanimer traumatic event even	Ϋ́	Sharon Donald				Street and Numb					
ē,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		20a. Method of Disposition	_	20b. Place of Dispo	Sition (Name	inia A	ve.,	Balti	more, 20c. Location - C	MD 2 lity or Tow	21221 n, State
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	Physician /Medical Examiner	je.	23a. Part 1. Enter the disease, or constock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any location to improve the conditions.	a. <u>Diffus</u> Due to (or	sed the death. Do not en h line.  Se pulmonary as a consequence of):				respiratory arre	est,	1 1	Approximate nterval Between Onset and Death Weeks
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on	ding th. Afte fune	힐	1 Natural 5 Pending 2 Accident investigati	(Month, I	Day, Year) Injury	M Zoo	lnjury at Work? 1 ☐ Yes 2 ☐		ou. Describe not	w injury occurred	1	
Divisi	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification: To	3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of	Injury - At home, farm, stretc. (Specify)				Bf. Location (Str. City or Town,	eet and Number State)	or Rural F	Route Number,
	the Hospi in 24 hou the Funer	Medical (	29a. Certifler 1 Certifying I (Check only one) 2 Medical Ex	Physician: To the be aminer: On the basis and manner	st of my knowledge, deat s of examination and/or in stated.	n occurred at vestigation, ir	the time, date an my opinion, dea	nd place, ar	nd due to the ca d at the time, da	use(s) and man te and place, an	ner as sta d due to tl	ted. he cause(s)
_	To t To t	Σ	29b. Signature and title of certifier		$\wedge$		icense number			d. Date signed	Month, Da	ay, Year)
			Hener !	1. Vieou	Jan 1		030206			1/11/10		
			30. Name and address of person wh	o completed cause o	f death (Item 23a) (Type,	Print)						
			Steven H. Pearlma 31. Date filed (Month, Day, Year)		6701 N.Charl strar's Signature	es Str	ceet,Bal	timor	e, MD	21204		
	Stat Registra		-11-2	2010 32. Regis	and a digitature							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death T. Decadent's Name (First, Middle, Last) 4:13PM **Physician** 01 2010 tricia /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner altimore Homestead 1timore 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days 1 □ M 2 🖫 F Yrs 10-30-1947 220-66-1977 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10h. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If w Medical Exact it we must be rediffed at once. 1 ☐ Yes 2 ☑ No **Funeral Director** timore 10g. Citizen of What Country? 10e. Street and Number 6 Homestead 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married 215-0036 1 □Yes 2 No Specify: ģ Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) abked 18. Mother's Name (First, Middle, Maiden Surname Maryland Be ( 17. Father's Name (First, Middle, Last, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Infermant's Name/Relationship (Type. Print) Owin SMillSMD 21117 20c. Location - City of Town, State Homestead Dr. harlenell. Baltimore, Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Llawn 1-12-2010 Badtimore, md 22. Name and Address of Facility Vaughn C. Greene Funeral Service 1 Burial 2 Cremation 3 Removal from State ood lawn 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Balto. MD 21229 Immediate Cause (Final disease or condition resulting in death) ndiovascu Physician Arteriose /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue to for as a consequence of) Examine requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown 5 ☐ Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 KNo 1 ☐ Yes 2V No Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To ð 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 24 hours after death • Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

> M:1

30. Name and address of person who completed cause of death (1 m 23a) (Type, Print)

MD

01/05/2010

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J

(rimb

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Shirley E. Fair 4:00 PM January Medical 2016 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign June 30, 1930 1 M 2 XX Months Days Director 218-26-8171 Maryland 79 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location must be notified at 10d. Inside City Limits Director Maryland N/A Baltimore XX Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? items 23a 3037 Keswick Road 21211 USA Department of Health and Mental Hygiene. In properties any injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2XX No 1 ☐ Yes XX No Specify: Specify: White 3

☑ Widowed 4 □ Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Manager Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Louis Daniel Bopst Katherine Havnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Rutkowski Sister 837 W. 33rd Street, Baltimore, Maryland 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery 20c. Location - City or Town, State 1 🔀 Bunal 2 🗆 Cremation 3 🗆 Removal from State 1/13/2010 Woodlawn, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 23a. Part 1/Pinter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed and Due to (or as a consequence of): Physician/Medical attending physician IF FFMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months ρ Month Day Year 1 ☐ Yes 2 L 9 ☐ Unknown cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 Yes Other: 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Beath Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0067741 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Menorial Hospital, Baltimore, MD Walid Barbery

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year anam 4:12 PM (1 para January 2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) County of Death Examiner Prince Georges 403 Weldon mple If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Year) Months 1 ☐ M 2 🕱 F 23-56-9350 Director Washington Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ia or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Naryland Prince Georges 1 ☐ Yes 2 No Directo 1emple 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 440 20 "natural", or items 23a edical Examiner must b Funeral . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 Nidowed 4 Divorced Iac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 00K Army Navy Country Club 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type. Print) Department of Health and Important: if Item 27 is m any injury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greenwood Dr. Woodbridge, Va. 22193 helma Graham. Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 2010 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jakes Chinn Funeral Service 2605 S. Shirlington Road Artington 22006 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metistatic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to in reduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a pansagreence off: Examine The law requires that the death certificate be executed physician and s the bunal-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 █ No Day Year 4☐Pregnant at time of death signed by the a d be detached for 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death uneral Director: 3 ☐ Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 **Ercertifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) TLAND HEALTH & WELLNESS CENTED 555 38 11 2010 SILVER HILL RD 5001 Silver Hills Ro 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar Debra

31. Date filed (Month, Day, Year)

Vereen

JAN 12 2010

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82. Registrar's Signature

Suitland

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20 AM Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral Month, Day 1 M 2 D F Months Min. Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits at 10a, State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Examiner must be notified 1 🗓 🗴 2 🗆 No timore 10f. Zip Code ò 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 4403 2120 elle or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Yes 2 N Maryland 21215-0036 1 Yes 2 1 No Specify: Black If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) . Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau nD 21207 altimore, 20a. Methogrof Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cremator 4 Donation 5 Other (Specify) permit. 21. Signature of Funeral Service Licenses a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner pirate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-tran Due to (or a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy ned by the atter s detached for u in the past 12 months? Day 5 Other (specify) Pregnant at time of death 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 2 ☐ No 3 ☐ Probably 4 XUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe this certificate has □ No Yes 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner? 2 No Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred s after death. I Director: After t 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Date signed (Month, Day, Year) 29b. Signature

State Registrar Name and address diperson who completed ca

31. Date filed (Month, Day, Year)

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Harry A. Helm 2:20 a<sup>M</sup> /Medical January 2010 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 7912 Greentree Road Rethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year 8/14/1920 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Funeral Months Days Hours Min. 1₹ M 2 □ F 496-30-5114 89 MO Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☑ No Directo MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7912 Greentree Road 20817 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1. □ Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2☐ Married Baltimore, Maryland 21215-0036 1∐Yes 2√ZNNo Specify þ Specify: WWII 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, Item of Engineering Mathematician 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Arthur Helm Helen Francis Hohman ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy Helm Al-Mulla, daughter 7912 Greentree Rd. Bethesda, MD 20817 Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2XXX Cremation 3 ☐ Removal from State Chesapeake Crematory 1/8/2010 Beltvsille, MD 4 ☐ Donation 5 ☐ Other (Specify) M0153922. Name and Address of Facility Rapp Funeral & Cremation Svcs. 21. Signature of Funeral Service Licensee 933 Gist Ave. Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician <u>Arteriosclerotic vascular disease</u> /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Exami sician and burial-tran Due to (or as a consequence of) physician s the burial Box 68760, Physician/Medical attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death P.0. signed by the a 1 □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 2 🗆 No 1 ☐Yes 2 🖫 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 \$\frac{10}{20}\$ Residence 6 Other (Specify) 1 Tes 2FXN0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1x Natural death. n 24 hours after death. e Funeral Director: A letely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending within 2.

> State Registrar

DHMH 17 Rev 1/2001

completely

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George W. Graves, MD; 5330 Wisconsin Ave. Ste. 1400; Chevy Chase, MD 20815

₹⊈Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D29353

29c. License number

29d. Date signed (Month, Day, Year)

1/7/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician /Medical 4a. Facility Name (If not institu 4c. County of Death Examiner Baltimore Madical Center If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 👿 Director Usual Residence of Decedent 10c-City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show or other traumatic event, the Mudical Exercitor is ust be notified at 1 Ves 2 No Director more 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 2121 3816 "natural", or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14 Bace - American Indian 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DOINOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmets. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname Be ebror ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18966 PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method f Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Balto MU 4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Service License erne Fymeral Services 21229 10altimore Nat 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician a s the burial-t revacoabdonemal aux canauxysu Physician/Medical attending p use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy perform certificate 2 No 1 ☐Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗖 No Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 2 🗌 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and Name and address of person who completed cause of death (Item 23a) (Type, Print)

State
Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

De B. farle

Graine Street Baltimora,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1985518 205PM 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) 6. Sex Date of Birth **Funeral** 1 🗆 M 2 🗶 F Months Hours Min. Director Usual Residence of Decedent 28a-f show 10a. State 10b. County Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Yes 2 ☐ No  $\mathbf{Y}_{D}$ 10e. Street and Number 6 10g. Citizen of What Country? should be filed within 72 hours after death with t and Mental Hygiene.

is marked other than "natural", or items 23a. Funeral lervace 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Black Specify If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide ၉ 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Method of Disposition Place of Disposition (Name of Jucil lawin crematory or other p Burial 2 Cremation 3 Removal from State 21. Signature of Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition PTICEMIA Physician Medical resulting in death) Due to (or as a consequence of) <sup>#</sup>Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of LING CANCER Cause (Disease or iinjury that initiated events resulting in death) Last and -tran Due to (or as a consequence of) the burialthe attending physician ched for use as the burial Physician/Medical requires that the death certificate be Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Eetal death 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by by INCARCITION. Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? PANCYTOPENIA 24a. Was an INTRAVASCULAR COAGULATION Hospital or Attending Physician: The law page 2 s autopsy performed? has ANEMTA this certificate 1 Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After injury 1 Natural 5 Pending Division Accident Investigation 6 Could not be 3 Suicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of contifie 29d. Date signed (Month, Day, Year) 2 hitrat 0.1/08/10 RESOUD 5601 LOCH RAVEN BLVD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SAMARITAN HOSPITAL. DHITAL. SALTIMERE 31. Date filed (Month, Day, Year)

JAN 1 2 2010

DHMH 17 Rev 7/2009

State Registrar

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Registrar's Signature

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	Physicia	n/	Decedent's Name (First, Middle	, Last)	,1/14/10 + ALK			Death	<ol><li>Date of Dea Month</li></ol>	Reg. No. Cath Day	Year	3. Time of Death
	Medic	al	4a. Facility Name (if not institution,		TTUE	EKS		Location of Death	101		y of Death	IVI
	Examin	er	Anne Arundel M	-	r		Annapol				Arun	del
	Funeral Director	Y	5. Social Security Number 098–34–1688	6. Sex 1 M 2 G F	e (In yrs. last b	b <i>irthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept. 2	1932 29,1932	9. Birth	place (State or Foreign Land
_	d t ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loc	ration					10d. Inside City Limits
	arylan a-fsh fied a	Director		Arundel	Loth		Jacon					1 ☐ Yes 2 🔀 No
	the M or 28	ij	10e. Street and Number		10f. Zip Code					10g. Citizen of	What Cou	ntry?
	h with ns 238	Funeral	254 Fifth Stree					)711		United		
036	s after deat ral", or iten Examiner r		<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Marris</li><li>3 ☒️Widowed 4 ☐ Divorced</li></ul>	If Vec Give		If	Vas Decedent of Hi FYes, specify Cuba ☐ Yes 2 XNo	n, Mexican, Puerto	ecity Yes or No- Rican, etc.)	Bla	ice - Ameri ack, White, y: <b>Whi</b>	etc.
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If team 27 is marked other than "natural", or items 23a or 28a-f show amy fount or other traumatic event, the Medical Examiner must be notified at once.	Completed by										ndustry Printing
	be filed w ental Hygi ked othe c event,	Be	17. Father's Name (First, Middle, L	ast)				18. Mother's Nam				
ylaı	ald be Menta narkec natic e	욘	Robert Halker						rine Mad			-
	12 should alth and M 27 is mar r traumat		19a Informant's Name/Relations Renee Neuens Renee Newens/	nip (Type, Print) Daughter	1		ng Address (Street a Rilian Co					
Baltimore,	of Heal of Heal if item	3	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation			e of Dispos etery, crem	sition (Name of natory or other plac		Date	20c. Location	- City or T	own, State
tim	t. Page tment c rtant: If ijury or		4 Donation 5 Other (S	Specify)			ematory_		10 l			Maryland
Bai	permit. Page Department. Important: I any injury or once.	)	21. Signal le Funeral Service L	1/20	ce Ise	40.00	. Name and Addres	-		_		aryland, Inc.
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused							r y rai	Approximate
F	h sician/	8 9	Immediate Cause (Final disease or condition	Bil	aAera	I l	ower	utron	J, 9	organs	ne	Onset and Death
	Medical Examiner		resulting in death)	Due to (or	Due to (or y a consequence of):  yea  yea							ylan
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3876	artificat ding ph	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy	,				004.5	ata af dali	
P.O. Box 68760	ne death ce the attenc ched for us	Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal de	eath 3	Ectopic pregnand Other (specify)	>y	100.00		ate of deli	Day Year
P.0	that the ned by e detain	y P	Part II. Other significant condition	· A	out not resulting	ng in the u	inderlying cause giv	ven in Part I.				the cause of death?
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ecor	elawe haste ge 2sh	omple									prior to c death?	opsy findings available ompletion of cause of
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<b>Vit</b>	hysici his ce al direc	은	examiner? 1  Yes 2 No		ent 2 ER			4 ☐ Nursing H	ome 5 Resid			<u>5y)</u>
n of	ding P th. After t funera	cate:	27. Manner of Death  1 Natural 5 Pendin 2 Accident Investi	ng 28a. Date of inju (Month, Da		b. Time of injury	work		28d. Describe h	now injury occu	rred	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be within E4 hours after death certificate has been signed by the attending physicis or the Funeral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur	l Certificate:	3 Suicide 6 Could 4 Homicide detern	not be		e, farm, stre	eet, factory, office		28f. Location (S City or Tow		ber or Rur	al Route Number,
_	To the Hospital within 24 hours of To the Funeral Completed filled	edical	(Check 2 Medical I	g Physician: To the best of Examiner: On the basis of e g Nurse Practioner: To the	examination ar	nd/or invest	tigation, in my opinio	on, death occurred a	at the time, date a	and place, and o	ue to the c	ause(s) and manner stated.
	To the within To the compl	Σ	only one) 3 L Certifying 29b. Signature and title of certifie		l l	lowledge, (	29c. License	e number		29d Date sign		
	(4)		My	1 Ali	NA V	<b>√</b>		21438			ary (	08, 2010
			30. Name and address of person	1. CORENTA			EFENSE }	tighwa	My ANNO	A POLI) Y	n Nz	140/
	Sta Registr		31. Date filed (Mann Pay Year)		ar's Signature		Mad					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2010 ar Harrison January 6:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 766 Powhatan Beach Road Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 27,1914 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Months Days Hours Min. 95 Director 218-30-7170 Baltimore, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov Directo MD 1 ☐ Yes 2 ☐ No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 766 Powhatan Beach Road Funeral death USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 📉 No þ Specify Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, Item 2008. Own Home Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Louis Fefe1 Mary Ann Gallagher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 766 Powhatan Beach Road Mrs. Bernadette Collins Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 4 Donation 2 Cremation 3 Removal from State 1/9/2010 5 ☐ Other (Specify) Catonsville, MD Resurrection Acres 21. Signar of Funeral/Service Livensee 22. Name and Address of Facility Singleton Funeral and Cremation M01220 Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part i Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as \*consequence of): Examiner Sequentially list conditions, if any county county county cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 ; 2 1 No 1 □ Yes 2 1 NO 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Perdence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Dav. Year) 102009 30. Name and Lot 31. Date filed (Month. Da Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #31, per DVR 8899 1/12/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Jan Year **Physician** Elaine J. Harvey 2010 6 9:00 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Northwest Hospital If Under Tyear Ist Under 24 Hrs. 1 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sav **Funeral** 1□ M 🐰 🗆 F Days Min. 212-14-1699 87 **Director** 7-7-192 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at MD n/a Baltimore YQYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4220 Fairview Avenue 21216 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African-American 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 🏋 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than eny injury or other traumatic. Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James W. Johnson Elizabeth Woody ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4220 Fairview Avenue, Baltimore, MD 21216 Alice G. Jones/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Denoval from State 1-13-10 Arbutus, MD Arbutus Memorial Pk. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Whie Funeral Home P.A. of Balto. co. 21 Signature of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Do r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** D20 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 57 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? Month Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy certificate 2. No 1 □Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 LINT Certification: To 1 Inpatient 2 DEN/Outpatient 3 DOA this 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month Para Year) State Registrar

## 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Howard ratricia 0 Jan 5, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5134 Clifford Road Perry Hall If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 □ F Director Nov 16, 1955 214-66-0462 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and be notified an once. Director Maryland Baltimore Perry Hall 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5134 Clifford Road 21128 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2 □ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify. 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U. S. Postal Service R.C.A. Carrier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie B. Walls Charles A. Walls Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5134 Clifford Road Perry Hall, Maryland 21128 Monica Howard 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/12/10 Loudon Park Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Inter the disease, or complications that caused the feath. shock, or heart failure. List only one cause on each line. Do not enter the m Immediate Cause (Final Metastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 18 months? 1 ☐ Yes 2 ☐ No 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 2016 1 ☐ Yes 24a. Was an autopsy perform 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 5 Pending investigation 1 ☐ Yes 2 No 2 Accident To the Funeral Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after 4 Homicide

and manner stated.

un

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

29a. Certifier

(Check only one)

Kober 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

Medical

State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

N. Charles

KULO61ST

6569

24b. Were autopsy findings available prior to completion of cause of death?

3 Probably 4 Unknown

3. Time of Death

7:20p

Birthplace (State or Foreign Country)

10d. Inside City Limits

1x Yes 2 No

Approximate
Interval Between
Onset and Death
5 Months

Maryland

**Baltimore** 

U.S.A.

Baltimore, Md.

Black

Month

5 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D0056919 06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

iouso 1

21204

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year AM Minnie R. Hill 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rose a 13a are Hospital Center Himore Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1□ M 25 F 59 253-80-6710 Sept.2,1950 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Havre De Grace Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 USA 35 Rock Glenn Rd 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Ho If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status

1 □Yes 2 🖾 No

16a Decedent's Usual Occupation

Educator

20b. Place of Disposition (Name of cemetery, crematory or other place)

1202

3 Ectopic pregnancy

28c. Injury at Work?

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course of 
1 ☐ Yes 2 ☐ No

5 Other (specify)

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a conseruence of):

Due to (or as a consequence of)

If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

9 Unknown

Hospital:

5 Pending investigation

6 Could not be determined

of person who com

d title of certifier

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day, Year)

ertensi

to (or as a consequence of):

myocardi

Specify:

В

(Give kind of work done during most of working life. DO NOT use retired)

35 Rock Glenn Rd.

GreenMountCrematory | 15 10

22. Name and Address of Facility CALVIN 1412 E.

Black, White, etc.

Specify:

18. Mother's Name (First, Middle, Maiden Surname)

L.

Havre

Annie

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

16b. Kind of Business/Industry

Roberts

20c. Location - City or Town, State

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No

Month

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Montie, Day, Year)

24a. Was an autopsy performed 1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

2 ☐ No

28d. Describe how injury occurred

Balto, md.

". SCRUGGS FUNERAL HOME PRESTON ST. BALTO. MD 21213

Private School

Black

De Grace, MD 21078

Approximate Interval Between Qnset and Death

tours

ea rs

275

Year

4 Unknown

**Physician** /Medical Examiner

Physician

Examiner

**Funeral** 

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Evantual remained and once.

altimore, Maryland 21215-0036

MINNI

/Medical

10a. State

MD

1 ☐ Never Married 2 ☑ Married

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+) 3yrs

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

20a. Method of Disposition

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months?

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death 1 Natural

2 Accident

4 ☐ Homicide

(Check only one)

Name and address

3 Suicide

29a. Certifier

29b. Signatur

9 Unknown

disease or condition resulting in death)

IF FEMALE:

17. Father's Name (First, Middle, Last)

Willie C. Jackson

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

Signature of Funeral Service License

James T. Hill/ Husband

1 ☐ Burial 2X Cremation 3 ☐ Removal from State

Director

Funeral

2

Completed

Be

ဥ

as the burial-transi and physician Physician/Medical the attending for use detached

P.O. Box 68760,

Division of Vital Records,

Examiner

Completed

Be

٩

Certification:

Medical

the death certificate be executed signed by i After this certificate has been or Attending Physician: funeral director, To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completely filled in by the fu death.

State

Registrar DHMH 17 Rev 1/2001

Franklin Square Mive, Baltimore IMD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

MIEC

**ORIGINAL** 

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

10-00188 Joseph Jackson		Please Type or Print in Black Indelible Ink. Ensure All Copie		ible.	
Joseph Jackson		State of Maryland / Department of Health and Mental H Certificate of Death Registrar		2010	00353
Physician Medical Examine	1/	1. Decedent's Name (First, Middle, Last)  JOSEPH Jackson	2. Date of Death Month January 7, 2	Day Year	3. Time of Death 1100 hrs
		4a. Facility Name (if not institution, give street and number)  2705 East Biddle Street  4b. City, Town, or Location of Death Baltimore		4c. County of Death	}
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	_	Foreign	nplace (State or Intry) Marylaul
Maryland 28a-f show any 1 at once.		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location Augusta			10d. Inside City Limits 1 Ves 2 No
vith the Maryland s 23a or 28a-f shov enotified at once.	[발	3540 Kindling Dr 10f. Zip Code 30906		Citizen of What Coun	
fter death wir	Fune	11. Marital Status  1 Never Married  2 Married  1 Never Married  2 Married  1 Yes  2 No  3 Widowed  4 Divorced If Yes, Give Year  1 Yes  2 No  3 No		14. Race - Americ White, etc.	an Indian, Black,
36 in 72 hour han "natu iical Exan	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)		6b. Kind of Business/Ir	ndustry
e, MD 21215-0036 i and 2 should be filed within 72 Health and Mental Hygiene item 27 is marked other than r traumatic event, the Medical	Be Com	17. Father's Name (First, Middle, Last)  18. Mother's Name  Control  Contro	e (First, Middle, Ma	iden Surname)	3
ore, MD 212 ss i and 2 should be of Health and Menta If item 27 is marke her traumatic even	<u> </u>	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or F  2705 E Biddle S  20a. Method of Disposition (Name of cemetery,	t. Bo	er, City or Town, State, LHTMRe, 20c. Location - City or T	MD 21213
MOCE Pages i Tent of F		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:	3 2010	Baltimo	re, mo
Balti Permit. Departu Importa		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o		Tunulal More, Mit, shock, or heart	Approximate Interval
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Heroin intoxication  Due to (or as a consequence of):			Between Onset and Death
	<u> </u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of highly \$ fait initiated co.			
an and	ᇙᅡ	events resulting in death) Last  Due to (or as a consequence of):  d.  AMENDED 22 - 27 29 - 5 - 2 - 27 29 - 2			
760, cate be cate be physicia	ē l	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery	
ords, P.O. Box 68760,  w requires that the death certificate be ex s been signed by the attending physician should be detached for use as the burial	잃	3b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)  9 Unknown	ancy	Month D	ay Year
S, P.O. Be interest that the de n signed by the detected for the detected	ਨ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 Yes	2 No 3 Proba	ably 4 🗸 Unknown
tal Record tian: The law req certificate has bee	Completed		24a. Was an autopsy perform	prior to co ed? death?	opsy findings available ampletion of cause of
/ital F	o Re	25. Was case referred to medical examiner?  1 V Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 1 Nursin		esidence 6 🗸 Other:	Scene
n of Vil ding Physic h. After this		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?  (Month, Day, Year)	28d Describe ho	w injury occurred	
Division of spiral or Attending hours affer death or affer death or filled in by the funer	ertificati	2 Accident Investigation Fd 1///10 Fd 10:45 am		eet and Number or Rur. te2705 E. Bi	al Route Number, City
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring and its control of the function o	. ا <u>ق</u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	due to the cause(	s) and manner as state	d
	₩ .	29b. Signature and title of certifier  Car of Hollan  O.C.M.E.		29d. Date signed (Mon January 8, 2010	'h, Day, Year)
DV		30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	1		
Stat Registra		31. Date filed (Month, Day, Year)  JAN 1 2 2010  JAN 1 2 2010  JAN 1 2 2010			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend # 17 per Inf G904 6/1/10 TT
State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day Physician Year McDaniel Johnson 2010 9:35p M Sr. 01 80 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 6903 Bexhill Road Apt. U.S.A. Baltimore | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) | 08/08/1924 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthdav) Funeral 6. Sex 1 XM 2 ☐ F Months Days Yrs. 85 Director 216-18-6981 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Exeminer must be notified at Director 1 Yes 2 □ No N/A MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 6903 Bexhill Road Apt 2B 21244 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Specify: 1946 Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Engineer School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel ၉ Sr. Johnson Harriett T. Lee <del>Danie</del> R. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6903 Bexhill Rd Apt 2B, Balto., MD 21244 Bernice Johnson (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD National Cem. 01/14/10 | Laurel, MD 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 amo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cance - 7 - Tears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes —2 ☑ No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier TZ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1737573 11,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore coffin ? 2835 32. Resistrar's Signature State 31. Date filed (Month Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Mary		artment of F tificate of L			liene 2010	00355	
	Physicia Medic		1. Decedent's Name (First, Middle, Last)  George H.	Kelley				2. Date of Deat January	10° 201'0° 10° 10° 10° 10° 10° 10° 10° 10° 10° 1	3. Time of Death 9:30 p M	
	Examin		4a. Facility Name (if not institution, give stree Rockville Nursing			4b. City, Town, or Rockvill	Location of Death		4c. County of Death Montgomery		
	Funeral Director		016-20-7763		yrs. last birthday) 34 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept • 2	9. Bir 27,1925 Mas	thplace (State or Foreign suntry) sachusetts	
	aryland a-f show iied at	Director	Usual Residence of Decedent		c. City, Town or Loc	eation Poto	omac			10d. Inside City Limits 1    Yes 2 □ No	
	vith the Ma 23a or 28 Ist be noti	eral Dire	10e. Street and Number 10550 Falls Rd.	<u>-</u>	<u>-</u>	10f. Zip Code	20854		10g. Citizen of What Co United St	ountry?	
980	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by Funeral		Was Decedent Ever Armed Forces? 1XXYes 2 No If Yes, Give Year or Dates.	l1	Was Decedent of Hi f Yes, specify Cuba	ın, Mexican, Puerto		14. Race - Ame Black, Whit Specify:		
Maryland 21215-0036	vithin 72 hou liene. er than "natu the Medical	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Seconday (0-12)		(Give F	lent's Usual Occup kind of work done o O NOT use retired) talargica	during most of wor		16b. Kind of Business	Industry  Government	
land 2	d be filed v fental Hyg irked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Arthur Leslie	e Kelle	-			ne (First, Middle, N		erson	
	age 1 and 2 should be file ont of Health and Mental F it: If item 27 is marked o y or other traumatic eve		19a. Informant's Name/Relationship (Type, I Christina Kelley S	<sup>Print)</sup> (Daught Saavedra	*1	ng Address (Street a			City or Town, State, Zi	p Code)	
Baltimore,	permit. Page 1 and Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	Chesapeak	natory or other place e Cremato	ory 1/12	/2010	20c. Location - City or Beltsvill	e, MD	
Balt	permit. Departi Import any inji		21. Signatura Funeral Service Licensee	МО					al & Crema g, Marylan	tion Service d 20910	
	Pnysician/		23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one ca Immediate Cause (Final disease or condition	use on each line.	e death. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death	
-	Medical Examiner	er	resulting in death)  Sequentially list conditions.	Due to (or as a co	onsequence of):	allere					
	cuted and transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c	Due to (or as a co	ertension	e Hourt	Disease				
09,	rate be executed physician and the burial-transit	edical E	resulting in death) Last	Dew	ventier						
. Box 687	death certific ne attending ed for use as	Physician/Me	in the past 12 months?	If yes, outcome of p 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	су		23d. Date of de Month	elivery Day Year	
ls, P.O.	Attending Physician: The law requires that the de *r death.  scrot. After this certificate has been signed by the by the funeral director, page 2 should be detached	þ	Part II. Other significant conditions contrib	outing to death but n	not resulting in the u	nderlying cause giv	ven in Part I.		bacco use contribute to	o the cause of death? Probably 4 Unknown	
Division of Vital Records,	The law req ate has bee page 2 shou	Completed			·			24a. Was al autops perfori 1  Yes	med? prior to death?	utopsy findings available completion of cause of	
Vital	<b>ıysician:</b> The is certificate director, pag	To Be (	25. Was case referred to medical examiner?  1 ☐ Yes 2 M No	oital:	2 ER/Outpatien	Oth	ace of De. th (Checer:	ck only one)	ence 6 Other (Spec	cify)	
on of	ending Pt sath. vr. After th he funeral	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Ye	28b. Time of injury	work	y at		ow injury occurred		
Divisi	ital or Atternatives after de ral Directo		4 - Homicide determined	28e. Place of Injury - building, etc. (S	Specify)			City or Towr			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director After this certific completed filled in by the funeral director,	Medical	only one) 3 Certifying Nurse Pr	On the basis of exam	nnation and/or invest	death occurred at th	e time, date and pla	ce, and due to the	cause(s) and manner as	stated.	
	<b>८</b> ∰ <b>८</b> ∑		29b. Signature and title of certifier	Joseph	4	29c. License	047330	2	January 1		
			30. Name and address of person who comp Thomas Joseph, M.I	50 W	. Edmonst	on Dr., S	Suite 207	, Rockvi	11e, MD 2	0850	
	Sta Registr		31. Date filed ( <i>Month, Day, Year</i> ) <b>JAN 1 2 2010</b>	32. Registrar's	Signature	e e					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Reg. No. 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Walter F. Kennedy :35AM 9th 2010 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Perning Parkway Center Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 20, 1934 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days 1 ■ M 2 □ F 75 219-30-0871 Maryland Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show a 1 ☐ Yes 2 No notified Director Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be r 2903 Hiss Ave. 21234 U.S.A. "natural", or items 23s Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4X Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygienn Important: If flem 27 is marked other tha any Injury or other traumatic Truck Loader - Morgan Mill Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Fraces Kennedy, Sr. ٥ Mary Francis Doyle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Mrs. Bernadette Kennedy 2903 Hiss Ave. Parkville, Maryland 21234 Law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/12/2010 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery Parkville, Maryland 21. Signature of Funeral Service Licenses 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Evans Funeral Chapel & Cremetion Services — Parkville 8800 Harford Road, Parkville, Maryland 21234 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration pheumonia /Medical Due to (or as a consequence of) Cerebral Astery Stroke Examiner Middle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner Hypertension
Due to (or as a consequence of): burial-trar ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ tron 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Tobacco 24a. Was an has autonsy performed? 1 Yes 2 No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 M Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident after death.

Director: / 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 😿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, that the death certificate be 0

executed

Baltimore, Maryland 21215-0036

Hospitai within 24 hours a the

State Registrar

31. Date filed (Month, Day, Year)

SAIMA

29b. Signature and title of certifier



Khow

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

1801

0028

Baltimore

wentworth

MD

29d. Date signed (Month, Day, Year)

Januan

Koad

21234

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** 201º0 Irvin Frederick Kemp, Jr. January 9:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore

Honor | If Under 24 Hrs. | Adding | Adding | Adding | Adding | Baltimore | Balt 3346 Woodside Drive Baltimore County

9. Birthplace (State of Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Funeral Hours Year) 1 M 2 □ F Months Days 214-20-7422 Director 84 January 6, 1926 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examples must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3346 Woodside Drive 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Mayes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: Ş Q Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed within and Mental Hygiene. News Film Cameraman- WMAR Broadcasting 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irvin Frederick Kemp, Sr. ျ Clara Lillian Brandt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau Mrs. Anita Kemp (Spouse) 3346 Woodside Dr., Baltimore, Maryland 21234 Baltimore, 20b. Place of Disposition (Name of completely, crematory or other place)

Evans Funeral Chacel

Bel Air 20a. Method of Disposition 20c. Location - City or Town, State 12, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Jan. 4 ☐ Donation 5 ☐ Other (Specify) 2010 Forest Hill, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Evens Funeral Chapel & Cremation Se

8800 Harford Road, Parkville, Maryl

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate Causé (Final disease or condition resulting in death)

a.

Due to (or as a consequence of): Evans Funeral Chapel & Cremation Services - Parkville 8800 Harford Road, Parkville, Maryland 21234 Approximate Interval Between Onset and Death **Physician** month /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.0. signed by the a I be detached f 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ 1 es 2 No 3 Probably 4 Unknown s peen s Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has e 2 s autopsy page ; certificate 1 □Yes 2 □No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After the 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation ours after death. Ieral Director: A filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mane Daller 02090 HX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 65-35 N. Operios St. Suite 550, Touson

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

hatten

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00358 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month John Henry Krumrein, Jr. 1:00 PM 2010 /Medical Januarv 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Roland Park Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 93 1 M 2 □ F 219-18-4201 Director July 26,1916 Maryland Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits show 2 should be filed within 72 hours after death with the Marylar and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Modeal Examinatine to notified at Director 1X Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4669 Falls Road 21.209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ∑Yes 2 ☐ If Yes, Give Year or Dates: <sup>2</sup>□No 1942 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 X No Specify Specify: White 3 ☐ Widowed 4 🎇 Divorced 1946 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Clothes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Heath and Menta Important: If Item 27 is marked c any injury or other traumant ပ John Henry Krumrein, Sr. Anna Rosina Goetz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Henry Krumrein, III, Son 20a. Method of Disposition P.O. Box 261 Lincolnville, ME 04849 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 01/09/10 Baltimore, Maryland 21. Signature of Funeral Service Lio nee Thomas Gregor <sup>22, Name and Address of Facility</sup> Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Effect Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) death certificate be executed resulting in death) Last Due to (or as a consequence of) physician a the burialburial Box 68760. Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy or Attending Physician: The certificate 2 🗓 No 2 ZNo 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manuer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

JAN 1 2 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

881

32. Registrar's Signatur

29c. License number

7727

29d. Date signed (Month, Day, Year)

08

			For State Registrar	5	State of M	laryland		rtment of F tificate of	lealth and I Death		giene / Reg. No. '	2010	00359
	Physici	an	1. Decedent's Name (First, N	•						2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic		Elizabeth							Jan.	9	2010	7:43 P M
	Examir	er	4a. Facility Name (If not instit						r Location of Death	1		County of Death	
			Genesis Spa  5. Social Security Number	6. Sex		ge (In yrs. las	st birthday)	Annapo If Under 1 Year	If Under 24 Hrs.	8, Date of Birt	Anne Arunde		
	Funeral Director		217-24-8728 Usual Residence of Deceden	1 □ M	1 2 X	82	Yrs.	Months Days	Hours Min.	May 2	v. Year)	$MD^{Cou}$	place (State or Foreign intry)
	yland now		10a. State 10b. Co			10c. City,	Town or Lo	ation					10d. Inside City Limits
	a-fsh	ctor	MD B	altimor	е	Cod	ckeys	ville					1 □Yes 2□No
	th the	Oire	10e. Street and Number					10f. Zip Code			-	en of What Cou	intry?
	ath wi	-a	221 Wickers		•				030			USA	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, if a Modical Evar	by Funeral Director	11. Marital Status 1 □ Never Marrled 2 □ 3 □ Widowed 4 □ Divo	Married	Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	? <b>X</b> 10		Vas Decedent of H FYes, specify Cuba □Yes 2 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		4. Race - Amer Black, White, Specify: W	
5-0	72 ho natur	etec	15. Dece (Specify only h	edent's Educat	ion o <i>mpleted</i> )		(Give	lent's Usual Occup	during most of wor	king	16b. Kin	d of Business/I	ndustry
121	12 should be filed within: h and Mental Hygiene. 7 is marked other than "fraumatic event, the Market	Completed	Elementary/Secondary (0-		College (1-4or	5+)		OO NOT use retired	d)		_		
2	iled v Hygie ther t		12 17. Father's Name (First, Mid	idle. Last)	4		Hom	emaker	18. Mother's Nan	ne (First, Middle,		wn Hon Gurname)	ne
au	d be i ental ked o c eve	To Be	John J. D		Sr.					y L. Ca			
Maryland	shoul nd M mari	<u>-</u>	19a, Informant's Name/Relat				19b. Mailin	g Address (Street	and Number or Ru	4		Town, State, Z	ip Code)
	1 and 2 s Health au tem 27 is		Joseph J. K	arl, Jr	./husb	and	1006	Tallwoo	d Rd., A	\pt. 1-C	C, Ar	napolis	s, MD 21403
J.e.	of He		20a. Method of Disposition			20b. Pla	ce of Dispo:	sition (Name of natory or other place	<sup>(2e)</sup> 1/13	Date 3 / 1 0	20c. Loc	ation - City or T	own, State
altimore,	t. Pa rtmer rtant:		1 Burial 2 □ Cremat 4 □ Donation 5 □ Othe 21. Signature of Funeral Ser	er (Specify)	noval from State	9	laney	Valley I	Memorial ss of Facility	Gardens			MD 21093
Ba	Depared Important any it		Michael	12 P 3			Le	emmon Fu	uneral Ho	ome of D	Dulan	ey Vall	ley, Inc. 1093
	Physician		23a. Part 1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition	e, or <i>c</i> omplicat List only one	tions that cause cause on each	ed the death. line.	Do not ente	er the mode of dying	ng, such as cardiad	or respiratory ar	rest,	1, WILD 2	Approximate Interval Between Onset and Death
	/Medical		resulting in death)	( a	Due to (or a	s a conseque							7000
	Examiner	_	Sequentially list conditions.	b									
	sit sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2	Due to (or a	s a conseque	nce of):						
	ficate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	с	Due to (or a	s a conseque	nce of):						
68760,	be e sician buria	a E		l	240 10 (0. 4		.,,.						
687	ificate g phys s the	edical		d		-							
O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □Yes 2 → No 9 □ Unknown	230	If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal d at time of dea	leath 3	Ectopic pregnand Other (specify)	у		2:	3d. Date of deli Month	very Day Year
<b>.</b> .	res that signed by		Part II. Other significant cor	ndltions contri	buting to death	but not resulti	ing in the ur	derlying cause giv	en in Part I.	23e. Did to	obac <i>c</i> o us	se contribute to	the cause of death?
rds Sp	quires an sig uld be	ed by								1 🗆 Y	es 2	<b>H</b> o 3□ Pro	obably 4 ☐ Unknown
of Vital Records,	aw requir is been s 2 should	Completed								24a. Was		24b. Were aut	topsy findings available ompletion of cause of
č	siclan: The law s certificate has t lirector, page 2 s	E								autop perfo 1 □ Yes	rmed?	death?	2 No
ita	lan: ertifica etor, p	Be C	25. Was case referred to me examiner?	dical					26. Place of Dea	ath (Check only o			
<u></u>	hysic this ce al dire	1	1 Yes 2 70	Hos		tient 2 El		t 3 DOA Oth	er: Nursing H	lome 5 🗆 Resid	dence 6	☐ Other (Spec	eify)
	ling Afte fune	ation:	27. Manner of Death  atural 5 Pe	ending vestigation	28a. Date of In (Month, D		8b. Time of Injury	28c, Injui Wor M 1 🗆	yat k? Yes 2 ∐ No	28d. Describe h	now injury	occurred	
Division	કે. <b>કે</b> . ફેંક	Certification: To		ould not be termined	28e. Place of Ir building, e	njury - At hom etc. <i>(Specify)</i>	e, farm, stre	eet, factory, office		28f. Location (S City or Tox		Number or Ru	ral Route Number,
	the Hospital hin 24 hours a the Funeral I mpletely filled	Medical (				of examination			me, date and place opinion, death occu				
	To the To the comp	M	29b. Signature and title of ce	rtifier	men	>		29c. Licens	32030		i	signed (Month	
	NV		30. Name and address of pe		oleted cause of		, , , , ,			AAD	2101	0	
	Sta	te	Dr. Gary Sp 31. Date filed (Month, Day, Y	(nor)	32. Regis	trar's Signatu	ro		., Chest	er, MD	2161	9	
	Regist		JAN12	חוח	Level 1	1	back	9					
	MU 47 D 4/6	004	SHUT 7	LUIU /	KARAN .	10.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day Month **Physician** 3:35 M Na -NNH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Months Days Hours 1 □ M 2 🔀 F 48 Jan. Director 6 2, 2010 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be muffled at once. 1 ☐ Yes 2 XNo Director Harford Bel Air Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21014 USA 905 Felicia Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🗖 No 2 If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jennifer Lynn Rexroth ပ Jeremy Michael Knapp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeremy Knapp / Father 905 Felicia Court, Bel Air, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn. 1-15-10 Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service License 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 10100515 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Fractor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician and for use as the burial-tran resulting in death) Last Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 1 ☐ Yes 2 🔀 No P.O. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by of Vital Records, 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 2 □No 1 Yes 2 No ospital or Attending Physician: Thours after death.

uneral Director: After this certifical if filled in by the funeral director, pa Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1∐Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 🙀 Natural 1 □ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

& GREENE

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ellani

22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00361 Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2 00HM Ε. Leonard hnuru 7.2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner A Maryland Nearth (Social Security Number 6. Sex 7. Age (In y If Under 1 Year 8. Date of Birth (Month, Day, Year) November 2,1927 9. Birthplace (State or Foreign **Funeral X**□ M 2 □ F Months Days Hours Maryland 82 Director 219-22-9765 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Forest Hill Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21050 202 Melissa Way USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Armed Forces? 1 □XYes 2 □ No filed within 72 hours after 1 □XYes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 9 1 ☐ Yes 2 ☐ No Specify þ Specify: White 3 ₩ Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Megines. United States Elementary/Secondary (0-12) College (1-4or 5+) Post Office 12 years Mail Carrier 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Thomas E. Leonard Mary Byczynski ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Melissa Way, Forrest Hill, Maryland 21050 Daughter Linda Engelmeyer Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 complications that caused the death.  $\Lambda$  o not enter the mode of dying, such as cardiac or respiratory arrest nly one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYNOW disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Dunknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 □ Yes 1 ☐Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Injury at Work? Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 072692 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Mrealth Care System, Perry Paint, mozing

State Registrar

31. Date filed (Month.

10-00180 Antonio Lashley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 00362

		1- For State Registrar			Certific	ate of	Death			R	leg. No.			
Physicia	ın/	1. Decedent's Name (First, Midd	le,Last)	-					2	2. Date of Dea Month		Year		3. Time of Death
Medical Examir	ner	Antonio	Ral	cim			Lashle	еу		January 7	7, 2010	real		0003 hrs
		4a, Facility Name (if not institution	on, give street and n	umber)		41	o. City, Town,	or Location	n of Death		4c. (	County o	f Death	
		University Hospital					Baltimore					N/A		
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last bin	thday)	If Under 1 You Months Da	ear If Un	der 24Hrs.	8. Date of Bi	rth(MM/DI	O/YYYY)	Foreign	hplace (State or
Director		214-33-0339	1 X M 2 F		21	Yrs.	IVIOLITIS D	ays   nou	is iviii,	05/2	4/19	88	Cou	intry) MD
	- [	Usual Residence of Decedent												
* any		10a. State 10b. County		10c	City, Town	or Locatio	n							10d. Inside City Limits
daryland 28a-f show any 1 at once.	5	MD Balt:	imore Co		Ell	icot	t Cit	У						1 Yes 2 X No
Maryl 28a-1	Director	10e. Street and Number	- · · · · · · · · · · · · · · · · · · ·				10f. Zip Code			1	l0g. Citize	n of Wh	at Coun	try?
the la or	ᆲ	9981 Old Fre	ederick	Road			2104	2			U.	S.A	. •	
ms 2.	Funeral	11. Marital Status	12. Was De		r in U.S.		Decedent of I				)- 14	4. Race White		can Indian, Black,
death or ite	اج.	1 Never Married 2 M	1 Yes	2 X	No			,		ican, etc.)		VVIIILE	, etc.	
after al", incr	질		vorced If Yes, Give Ye or Dates:				Yes 2 🔀 N						Bla	
hours		15. Decedent's Education (Spe					s Usual Occup st of working li				16b. Kin	d of Bus	iness/Ir	ndustry
72 n 72 n 22 ical 1	Completed	Elementary/Secondary (0-12)	College (	1-4 or 5+)				_				. ,		
withing the mer the Med	틹	9th Grade  17. Father's Name (First, Middle				Unen	nploye		ada Nama (f	First, Middle,		N/A		
filed at Hyg			, Last)		T l-	1			,			,		
21215-0036 suld be filed within 7 Mental Hygiene. marked other than it event, the Medica	Be	Antonio  19a. Informant's Name/Relations	shin /Tyne Print \		Lash		Address (Str		ria	D.	Bar nber City		State	Zin Code)
MD 2 id 2 shou lith and N m 27 is n	۵	Kevin Lashle		`	- 4	_								,
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	- 1	20a. Method of Disposition	sy (oncre	<del>,</del>	20b. Place	of Disposit	ion (Name of o	cemetery,		RU,EI Date				ty , MD 2 1 0 4 2 Fown, State
Ore ges 1 of H	- 1	1 Burial 2 X Cremation	n 3 Removal f	rom State	Jőse	PK OF	rown	F/H	1 .				•	
altimore, mit. Pages l ar spartment of Hee pportant: If ite pury or other tr		4 Donation 5 Other S			And	Crem	atory		[01/	15/10	Bal	tim	ore	, MD
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Oeparment of Health and Mental Hygiene Important: If item 27 is marked other timpury or other traumatic event, the Med		21. Signature of Funeral Service	Licensee	) 11	1 .	Jos	eph H	· Br	"own_	Jr. Fu	uņeŗ	al	Hom	e D 21217
		23a. Part I. Enter the disease, or	complications that	cell the	death Don	12 1 4	U N .	Fult	on A	ve.,Ba	alt1	mor	e,M	D 21217 Approximate Interval
Physician Medical		failure. List only one cause	on each line.			or eriter trie	s mode of dyn	g, suur as	cardiac or i	espiratory arr	631, 311001	, or rica		Between Onset and Death
Examiner	1	Immediate Cause (Final disease or condition resulting in death)	Due to (or as											Death
			b Due to (or as	a conseque	rice or).									
	힐	Sequentially list conditions, if any, leading to immediate	Due to (or as	a conseque	nce of):									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	C.											
1 8 · 8	\X	events resulting in death) Last	Due to (or as	a conseque	nce of):									
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3760, ficate be g physici s the buni	Ş۱	IF FEMALE: 23b. Was decedent pregnant in t			f pregnancy	. Eats	il death 3	Ector	oic pregnanc	·v		Date of o		ay Year
Sox 68' death certifice attending I for use as	Sia	past 12 months?	4 Preg	nant at time			er (Specify)		oro programa	,,		01101		100,
that the death certifued by the attending detached for use as	Physiciar	1 Yes 2 No 9 Un	known 9 Unkn	own			2. (-, , ,							
at the		Part II. Other significant condit	tions contributing t	o death but	not resultin	g in the un	derlying cause	given in l	Part I	23e. Did to	obacco us	e contrib	ute to t	he cause of death?
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cords, P.C. law requires that has been signed beta	쁄									24a. Was				opsy findings available ompletion of cause of
e law e has	Completed	· -								perfo	rmed?	, de	eath?	·
tal Re(cian: The certificate		25. Was case referred to medica	N .				26 DIa	ce of Deat	h (Check on	1 Yes	2 No	1	Yes	2 No
Vital Rec ysician: The l his certificate	Be	examiner?	Hanning	Innatient	2 <b>V</b> ER/O	utnatient		Other <sub>4</sub>		Home 5	Residenc	- 6	Other:	
n of V ding Phys a. After thi	의	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury		Time of Inj		jury at Wo		8d. Describe			,	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach.	Certification:	1 Natural 5 Pend	Ian (Mont)	Day, Year)	- 1	3 hrs		Yes 2	0	ubject sho				
Sicological Attentage of the sicological Psychological Attentage of the sicological Attentage of the si	g	2 Accident Inve	stigation 28e Plac	re of Injury	- At home, fa	arm street	, factory, office			8f Location (	Street and	Numbe	r or Run	al Route Number, City
Divisior spital or Attent ours after death eral Director:	틹	dete	ld not be	Local		, 50,550	, leading, amor	,		or Town, S 00 N. Frankl	State)			
lospit 4 hour uner		29a. Certifier	hysician: To the be			ath occurre	ad at the time	date and r						<del></del>
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - transi	lica	Torroom oray	miner: On the basis	of examina										
To To con	Medical	29b. Signature and title of certific	and manner er	stated.			29c. Lice	nse numbe	er		29d. Da	te signe	d (Mon	th, Day, Year)
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	-	20 Name and addition	6	/ <i>y</i>	(Itam 02=)							,,,,		
3		<ol> <li>Namé and address of persor</li> <li>Russell Alexander ME</li> </ol>				111	Penn Stree	t. Baltim	nore MD	21201				
	oto.			egistrar's S			31111 00100	., Daim	.5.5, 1415					
Sta Regist	ate rar	31. Date filed (Month) (Party Year)	2 2010 2	Grand		100	relati							
					-	1171					_			

Certificate of Death

2. Date of Death

**Physician** 11, Helen Marie Layaou January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 11918 Rocking Horse Road Rockville If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, **Funeral** Hours Months Days Min 1 □ M 2 🛛 F 233-42-1953 82 May 2, 1927 **Director** Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f sl Examinar in ust be notified Director Montgomery Rockville Maryland 10e. Street and Number 10f. Zip Code 11918 Rocking Horse Road 20852 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married , or Maryland 21215-0036 1 ☐Yes 2 No 3 ¥ Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Leona Garten Frederick Grimmett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Health a Robert L. Layaou / Son 11805 Browningsville Road, Monrovia, Maryland 21770 or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. Montgomery Crematorium, Inc Jan. 13, 2010 4 ☐ Donation 5 ☐ Qther (Specify) 21. Signature of Fungral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. 3rfe the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Physician Metastatic Carcinoma of the Ovary disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 X No 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 24a. Was an autopsy performe of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ∐Yes 2 X No Medical Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28c. Injury at Work? Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

West Virginia 10d. Inside City Limits 1 □Yes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. White Specify: 16b. Kind of Business/Industry Own Home 20c. Location - City or Town, State Bethesda, Maryland Approximate Interval Between Onset and Death 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 X No 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) January 11, 2010 1500 Forest Glen Road, Silver Spring, Maryland 20910

3. Time of Death

8:50

9. Birthplace (State or Foreign

2010

Montgomery

 $A^{M}$ 

Registrar

Robert H. Gerard, 31. Date filed (Month, Day, Year) **JAN 1 2 2010** 

29b. Signature and title of certifier

4 Homicide

29a. Certifier

determined

1. Decedent's Name (First, Middle, Last)

32. Registrar's Signatu

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

29c. License number

D0055522

			For State Registrar	State of	Maryland		rtment of H tificate of L		and Me		giene Reg. No.20	0	00364
			Decedent's Name (First, Middle, Last	)					2	2. Date of Dea	ath	·	3. Time of Death
	Physici /Medio	_	Elwood Vernon L	yon						Month Januar	,	Year 10	12:02 PM <sup>M</sup>
5	Examin	-	4a. Facility Name (If not institution, give	street and num	nber)		4b. City, Town, or	Location o	of Death		4c. County of	f Death	
r <sup>i</sup>			Lorien Mays Cha				Timoni		0411:-		Baltin		
	Funeral Director		$\alpha = \alpha =$	x ⊒M 2□F	7. Age (In yrs. Ia. 83		If Under 1 Year Months Days	Hours	Min.	B. Date of Birt (Month, Day June 2	7, 1926	Cour	place (State or Foreign htry) yland
	and w.		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	ation					1	IOd. Inside City Limits
	Maryl f sho	ţo	MD Baltimor	e		Cocke	ysville						1 ☐ Yes 2 ☐ No
	h the r 28a	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of W	hat Cour	ntry?
	23a c		2A Honeybee Cour	t				21	1030		USA		
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	Armed For			Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🎇 No	ispanic Ori <sub>i</sub> in, Mexicar <i>Sp</i> ec <i>ify:</i>	gin? (Spec i, Puerto R	ify Yes or No- ican, etc.)	- 14. Race Black Specify:	, White,	
8	2 hour atural cal Ex	ted k	15. Decedent's Edu	cation	44-46	16a. Deced	ent's Usual Occupa	ation			16b. Kind of Bus		
212	hin 7% e. an "na Media	Completed	(Specify only highest grad	le completed) College (1-	-4or 5+)	(Give I life. E	kind of work done of NOT use retired	during mosi )	t of working	9			
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Maryland 21215-0036	2 should be filed w n and Menta! Hygie Is marked other t raumatic event, th	Be	17. Father's Name (First, Middle, Last)								Maiden Surname	)	
$\frac{3}{2}$	hould d Mer marke matic	<b>T</b>	Elwood Vernon L			19h Mailin	g Address (Street a			elen G		Stato Ziu	Code)
<u>8</u>	and 2 s ealth an n 27 Is i		Virginia Lyon/s				Honeybee					210	'
altimore,	Pages 1 lent of He nt; If iter		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ f  4 ☒ Donation 5 ☐ Other (Specify,		l ce	ace of Dispos metery, cren	sition (Name of natory or other plac	e)	Da	ite	20c. Location - 0	City or To	own, State
Balti	permit. Departm Importa any inju		21. Signatura Funeral Service Licens		rector	S	Name and Addres tate Anat altimore	tomy :	Board 2120		. Baltim	roe	Street
	Physician	g 13	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cally (Final	lications that cannot cause on ea	)				cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
ŀ	/Medical		disease or condition resulting in death)	aDue to (d	or as a conseque		, Disc	1 DC					Minon
	Examiner		Sequentially list conditions,	b D-	y Sph	- 54	۷						1 year
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	as a conseque	equence Type							0
	cate be executed physician and the burial-transit	хап	that initiated events resulting in death) Last	c	r as a consequence of):							-	
8760	s be e sician buria	dical E		·	·								
89	ificate g phy as the	edic		u		-							
). Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year		- /				
о. О	hat the d by t letach	Phy	9 ☐ Unknown  Part II. Other significant conditions co	ntributina to de	ath but not result	ting in the un	derlying cause give	en in Part I		23e Did to	ohacco use contri	bute to t	he cause of death?
Vital Records,	w requires that the d been signed by the should be detached	ed by	Debuty	minuting to de	au but not result	ung ar the un	acitying vadoe give	511 HTT Q1C1.		1 🗆 '		3 ☐ Prot	
Rec	Physician; The law r r this certificate has be ral director, page 2 sh	Completed	_ Chronic C	mer	y rete	entro	``				osy property de	rior to co eath?	opsy findings available mpletion of cause of 2□ No
ta		Be C	25. Was case referred to medical					26. Place	of Death	1□ Yes (Check only o	* T		2   140
	nysic nis ce direc	To E	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Ir	npatient 2 E	R/Outpatien	: 3 □ DOA Othe	er: ▲ Nu	, ırsing Hom	e 5 🗆 Resid	dence 6 □Othe	r (Speci	fy)
u u	ding Ph n. After th funeral		27. Manner of Death  1. Natural 5 ☐ Pending	28a. Date o (Monti	of Injury h, Day Year)	28b. Time of Injury	28c. Injun Work	y at c?	28		how injury occurre		
<u>S</u>	or Attending latter death. Director; After in by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be	29a Plana	of injune. At hom	no form stre		Yes 2 □		Of Laurelian //	Ot		10
Division or	after of Direct of in by	Certification:	4 ☐ Homicide determined	buildir	ng, etc. (Specify)	ie, iaiii, siie	et, factory, office		20	City or Tox	Street and Numbe vn, State)	r or <del>n</del> ur	ar Houte Number,
	Hospita 4 hours Funeral tely filled	edical C	29a. Certifier (Check only one) CertifyIng Phy 2 Medical Exam	sician: To the iner: On the ba and mann	asis of examination	riedge, death on and/or inv	occurred at the tin restigation, in my o	ne, date ar pinion, dea	nd place, ar ath occurre	nd due to the d at the time,	cause(s) and mar date and place, a	ner as s	stated. o the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of pertifier	_			29c. License	e number		T	29d. Date signed	(Month,	Day, Year)
	> - 0		> Xilde		RO	295	y y		1/4/	201	0		
•			30. Name and address of person who d	ompleted cause	e of death (Item 2	23a) (Type, I	Print)						
			Susan ANTHUN	7			HARLES	50	- 57	= 405	Torra	the	MD 21204
	Sta Registi		31. Date filed (Month, Day, Year)  JAN 1 2 2010		egistrar's Signatu	BOA	D						

Division of Vital Records, P.O. Box 68760,	*	Baltimore, Maryland 21215-0036
To the Hospital or Attending Physician: The law requires that the death certificate be executed to such after death	Phy /M	permit. Pages 1 and 2 should be filed within 72 hours after Denartment of Health and Mental Hydiane
To the Funeral Director: After this certificate has been signed by the attending physician and	sid	Important: If item 27 is marked other than "natural", or it
sit	cia lica ine	any Injury or other traumatic event, the Medical Evanin

	1	For State Registrar		State	of Marylan		partmen <i>ertificat</i> e			nd Me	-	giene Reg. No. 1	2010	) (	003	65
Physicia	n	1. Decedent's Nam	ne (First, Middle	e, Last)						2	2. Date of De Month	Day	Year		Time of De 4:40	
/Medica			I. Mort	on n, give street and no	ımber)		4b. City,	Town, or I	Location of	Death	Jar	4c. C	10, 20 ounty of Deat	010 h	4.40	- AL1
				odbridge		la a A fa laska ada	lf Under	1 Voor	Cato	nsvi			Baltimo		(State or E	oroian
Funeral Director		5. Social Security f		6. Sex 1 ☐ M 2万F	7. Age (In yrs. 9)		Months	Days	Hours	Min.	B. Date of Bir (Month, Date 14	ı <i>y, Year)</i>	Co	untry)	(State or Fo	oreign
		214-16 Usual Residence o	of Decedent								Aug 1	±, 19.	1.5			
arylan show	۲	10a. State	10b. County		10c. Cit	y, Town or	Location								side City L □Yes 2	
r 28a-f show	Director	MD 10e. Street and Nu		timore	V	Vinds	or Mil.					10a. Citize	en of What Co			
3a or				ain Dood				21244					ited S		26	
ter death wi	Funeral	11. Marital Status	namberi	ain Road 12. Was Dec Armed F	cedent Ever in U.	S. 1	3. Was Deced			in? (Spec Puerto Ri	ify Yes or No		Race - Ame Black, White	rican In		
or it	by Fu	1 ☐ Never Mar 3 ☐ Widowed		ried 1 □ Yes If Yes, G	2⊠No ive		1 □Yes 2		Specify:				Specify:			
be filed within 72 hours after death with the Maryland nial Hygiene. Id other than "natural", or items 23a or 28a-f show event. It is Medical Evaluation in the notified at	ted t		15. Deceden	t's Education		16a. De	cedent's Usua	l Occupa	tion			16b. Kind	d of Business/	Whi Industry		
thin 72 e. an "na Medi	nple	(Spe Elementary/Sec		st grade completed College	(1-4or 5+)	(G. life	ive kind of wor e. DO NOT us	k done di e retired)	uring most o	of working	7					
ed wit tygien rer th	To Be Completed	12				N	ırse's			/-	First, Middle		ealth C	are		
intal H ed otl		17. Father's Name									reen	, Maiden S	umame)			
should nd Me mark matik	ř	19a. Informant's N	h Henry Name/Relations			19b. Ma	ailing Address	(Street a				er, City or	Town, State, 2	Zip Code	e)	
and 2 salth a 27 is er trau		Irene	Smith	/Niece		7	113 Ch	ambe	rlain	Road	d Wind	sor M	fill, M	D 2:	1244	
jes 1 a		20a. Method of Dis		3 ☐ Removal from	State 20b. F	lace of Dis emetery, o	sposition (Nan rematory or o	ne of ther place	)	Da .T.	te an 12,	20c. Loca	ation - City or	Town, S	State	
t. Pag rtment rtant: njury		4 ☐ Donation	5 Other (S	Specify)	Ch	_	ake Cre			2	010	Be	eltsvill	.e, ì	Maryla	ind
permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any Injury or other traumatic event. It is Med once.		21. Signature of F	uneral Service	Licensee -	14107	3		ation	and	Funer	al Alt					
		23a. Part1. Enter	the disease, or	complications that	caused the deat	h. Do not	8717 enter the mod	Gree e of dying	n Pas g, such as c	tures cardiac or	Drive respiratory a	Towse	on Mary	App	21280 roximate rval Betwee	
Physician		Immediate Cause	(Final	A1	_2/19	m E	K'S	DE	nen	TIA					et and Dea	
/Medical Examiner		resulting in death	)	Due to	(or as a conseq											
	Je.	Sequentially list or if any, leading to it cause. Enter Und	onditions, mmediate	b	(or as a conseq	uence of):										
cuted nd ransit	Examiner	that initiated even	r injury ts	<b>S</b> c												
ate be executed hysician and the burial-transit		resulting in death)	Last	Due to	(or as a conseq	uence of):										
ficate physi s the b	edical			d						,						
eath certific attending p for use as	W/u	IF FEMALE: 23b. Was decede			utcome of pregna		3 ☐ Ectopic p	regnancy				23	3d. Date of de	-		
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rai director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 1; 1 ☐ Yes 2 9 ☐ Unknow	2 months?		gnant at time of o		5 Other (sp						Month	Day	Yea	ır
that the				ons contributing to	death but not res	ulting in the	e underlying c	ause give	n in Part I.		23e. Did	tobacco us	e contribute to	the ca	use of dea	th?
quires an signal	Completed by	HYPERTE	NSIVE	CARDION	1ASCUL	AR	DISE	364			1 🗆	Yes 2□	] No 3 □ P	robably	4 Unk	nown
e law requir has been si e 2 should I	plet										24a. Was		24b. Were au	utopsy fi	indings ava	ailable se of
stcian: The la certificate ha rector, page?	Com										perfo 1 ☐ Yes	ormed? 2 No	death? 1 □ Yes	_		
certifican:	Be	25. Was case refe examiner?	_	Hospital:				Othe			(Check only					
Phys er this eral dir	2	1 Yes 2 2 27. Manner of Dea	≰No ath	28a. Dat	inpatient 2 e of Injury	28b. Tim		DA   Strict   1985   19	A LINGUI		e 5 ☐ Res 8d. Describe		Other (Spe	cify)		
nding Path.	atior	1 Natural 2 ☐ Accident	5 ☐ Pendir investi	9	nth, Day, Year)	Inju	y M		? ⁄es 2□N	No						
or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could detern	- t   Zoe. Flag	e of Injury - At he	ome, farm,	street, factory	, office		20		(Street and wn, State)	Number or R	ural Rot	ite Numbe	r,
pital o	S	29a. Certifier	1 Cortifui	ng Physician: To th	ne hest of my kno	wledge d	eath occurred	at the tin	ne date and	d place a	nd due to the	cause(s)	and manner a	s stated		
To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Aft completely illed in by the fur	edical	(Check only one)		Examiner: On the												
To the within To the comp	Me	29b. Signature an	d title of certifie	^	_			c. License					signed (Mont	-		
			~	M.	D			100	591	107		01.	-11-	2	010	
DV		30. Name and add	dress of person	who completed car	use of death (Iter	n 23a) (Tyl 1 <b>N</b> ES	pe, Print)	MER	DRI	31	R 215	JER	STOWN	V 2	MD 2113	6
Stat		31. Date filed (Mo	nth, Day, Year)	n 1 32.	Registrar's Signa	ature	2 10									
Registra	al .	JAN	1221	U fleren	C B.	gar										

		1 - For State Registrar	State of M	aryland / Depa	artment of F			ene2 ()   ()	00366		
Phys	sician	1. Decedent's Neme (First, Middle, La	ist)				2. Date of Death Month	Day Yeer	3. Time of Death		
The same of the sa	edical	Arree Ann Murph					January 7	7, 2010	1:10 p <sup>M</sup>		
Exa	miner	4a. Facility Name (If not institution, git 4502 Mustering 1			4b. City, Town, of Ellicot		ath	4c. County of Dea	th		
Fune	ral			ge (In yrs. last birthday)	If Under 1 Year			Howard 9. Bird	thplace (State or Foreign		
Direct		481-50-9688 Usuel Residence of Decedent	1□M 2 <b>∑</b> F	68 Yrs.	Months Days	Hours Mi	Oct. 24,	ear)   Co	ountry) Owa		
ryland	E .	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits		
Ba-f s	Director	Maryland Balti	more	Towso	n				1 ☐ Yes 2 No		
with the same or 2	Dir		12		10f. Zip Code	06		. Citizen of What Co			
death ms 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	212 Was Decedent of H		(Specify Yes or No- orto Rican, etc.)	United St			
Nore, Maryland 21215-0036  1ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Heatth and Mental Hygiene. In file marked other than "natural", or Itams 23a or 28a-f show or of their traumatic event, the Medical Examinar must be publised.	by Fu		Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:	No	If Yes, specify Cuba 1 ☐ Yes 2 <b>X</b> No		erto Rican, etc.)	Black, Whit	e, etc. White		
Maryland 21215-0036 Maryland 2115-0036 at 2 should be filed within 72 hours alt at and Mental Hygiers at 18 marked of ther than "natural", or traumatic event, the Medical Expent	ted	15. Decedent's E	ducation		dent's Usual Occup		16	b. Kind of Business/	Industry		
215 ithin 7	Completed	(Specify only highest gr. Elementary/Secondary (0-12)	College (1-4or	life.	kind of work done DO NOT use retired	during most of w d)		D			
d 21 filed w Hygier other th	So		5+	Psychi	atric So		ker	Private F	ractice		
d be f	To Be	G1 7 -					ame (First, Middle, Ma				
Taryla 2 should b and Ment is marked sumatice	۳	19a. Informant's Name/Relationship (		19b. Mailir	ng Address (Street	and Number or F	ine McGo	vern lity or Town, State, 2	Zip Code) 21 0/12		
Te, Mg 1 and 2 Health a lam 27 is		Robert Murphy/	Brother	4502	2 Muster				y Maryland		
Baltimore, permit. Pages 1 an Department of Heat Important: If itam 2 any injury or other		20a. Method of Disposition 1 Durial 2 ACremation 3 D	Removal from State		natory or other plac	эв) Jan.	Date 20	c. Location - City or	Town, State		
Itim it. Pa intmen intmen intent:		* 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Liger	y)	Metro Cre		201		ltimore,			
Balt permit. Departr Imports any inji	OUC	Illice la		ice Iser	99 Freder	cick Road	cemation So d Baltimore	ociety of e. Maryla	Maryland,Inc		
Syedo, Cate be executed by Skician and the burial-transit	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undershiping Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c.	a consequence of):  a consequence of):  a consequence of):	ovario	an ca	encer		Initerval Between Onset and Death 3 - J ycansi		
I Records, P.O. Box 68 The law requires that the death certifics tte has been signed by the attending pt bage 2 should be detached for use as ti	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year			
cords, P. w requires that been signed by should be deta	þ	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the ur	nderlying cause give	en in Part I.		co use contribute to	the cause of death?		
	Completed					·	24a. Was an autopsy performed 1 ☐ Yes 2 ☑	prior to death?	topsy findings available completion of cause of		
f Vita ysician: ysician: js certific director,	o Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital:		Othe		eath (Check only one)	- /	Frother's		
on of ding Phys h. After this funeral dia	n: To	27. Manner of Death	28a. Date of Inju. (Month, Day	nt 2 ER/Outpatien	28c. Injury	at Nursing	Home 5 Residence		Home		
ISIOF Ntandin death. ctor: Aft y the fur	atio	1 Natural 5 Pending investigation		Year) Injury	M 1□'	(? Yes 2 □ No					
DIVISION Of all or Attanding Physical atter death. In Director: After this of in by the funeral d	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ury - At home, farm, stre c. (Specify)	eet, factory, office		28f. Location (Stree City or Town, S		ral Route Number,		
DIVISION Of VITA  To the Hospital or Attanding Physician: within 24 hours after death.  To tha Funeral Director: After this certific completely filled in by the funeral director.	edical (	29a. Certifier  (Check only one)  Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)									
To the To the Comp	ž	29b. Signature and title of certifier	e Mil	( )	29c. License	number	29d.	Date signed (Month	, Day, Year)		
'V		76000	Cure	1 100	7) 2	1000	1/	15/2010			
12		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, F	Print) Carry	skell i	shed, wh	# Mari	6,000		
	State	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	,						

State of Maryland / Department of Health and Mental Hygier ( Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Date of Death 3. Time of Death Day Year Month **Physician** 2010 January 7, 11:45AM /Medical 4b. City, Town, or Location of Deeth 4a. Fecility Neme (If not institution, give street and number) 4c. County of Deeth **Examiner** College Manor Nursing Home Lutherville Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F Months Deys Hours Yrs. 79 June 18, 1930 Wheeling, WV Director 233-42-5580 Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other then "netural", or items 23a or 28a-f show other traumatic event, the Mactical Examinar must be notified at 1 ☐ Yes 2 No Director Baltimore Timonium 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21093 USA 2447 Springlake Drive Funeral 12. Was Decedent Ever in U,S. Amed Forces?

1 △ Yes 2 □ No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 end 2 should be filed within 72 hours after of teath and Mental Hygiene. Mm 27 is marked other then "netural", or iten 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 5+ Engineer Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Richard Thomas McCoy, Sr. 2 Doris Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if Item 27 is eny injury or other trau Martha A. McCoy/Wife 2447 Springlake Drive Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State Jan. 8, 1 ☐ Buria! 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 2010 Glen Burnie, MD 22. Name and Address of Facility emmon Funeral Home of Dulaney Valley, 21. Signature of Funeral Service Licensee 10 W. Padonia Road Michael Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) dementia 2 years Examiner Due to (or as e consequence of) Examiner physician and s the buriel-trensit Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Box 68760. Physician/Medical Due to (or as a consequence of): for use es ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown accident eprovascular δ should be 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Was en autopsy performed? 1 ☐ Yes 22 No 1 Yes 2 No of Vital 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) assisted Hospitel: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Definer (Specify) Living Medicai Certification: To 1 Yes 2 No this 28b. Time of Injury 28a. Date of Injury (Month, Dey Year) 27. Manne of Death 28d. Describe how injury occurred Division 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) after 4 Homicide filled To the Hospital
within 24 hours of
To the Funeral
completely filled 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture end title of certifier 29d. Date signed (Month. Dev. Yeer) 29c. License number servu 30. Name end eddress of person who completed cause of death (Item 23a)/(Type, Print) BRNCE ROSFINBERLO 31. Date filed (Month, Day, Year) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

JAN 1 2 2010

Funeral Director

y Year 2010  Country of Death  Baltimore  9. Birthplace (State or For Country)  10d. Inside City L 1 □ Yes 2 I  izen of What Country?  SA  14. Race - American Indian, Black, White, etc.  Specify: White ind of Business/Industry  ucation  Surname)  1a Meyers or Town, State, Zip Code)  1, MD 21084  coation - City or Town, State  sedale, Maryland  y Valley Inc. Maryland 21093  Approximate Interval Betwee Onset and Dea											
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Immediate Cause (FIRE)											
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use contribute to the cause of deat ☐ No 3 ☐ Probably 4 ∰ Onk											
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No 3 Probably 4 No											
No 3 Probably 4 No nk  24b. Were autopsy findings ava prior to completion of caus death? 1 Yes 2 No  6 Other (Specify)  ry occurred  and Number or Rural Route Number e)  a) and manner as stated. d place, and due to the cause(s)											
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No 3 Probably 4 No nk  24b. Were autopsy findings ava prior to completion of caus death? 1 Yes 2 No  6 Other (Specify)  ry occurred  and Number or Rural Route Number e)  a) and manner as stated. d place, and due to the cause(s)											
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No 3 Probably 4 No											
No 3 Probably 4 No											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Morgan udessia 6,2010 7:00A January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Riverview Nursing Home Baltimore Essex 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 ☐ M 2 🕱 F 105 820-03-2921 1-9-1904 MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2X No Baltimore Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 7040 Conley Street 21224 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐Yes 2 No Specify: Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eleanora Mae Kidwell Oden Kidwell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Heckrotte-Granddaughter 2126 Ruffsmill Road, Baltimore, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory 1-7-10 Baltimore, MD Bayview 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral S 2134 Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eneuna disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of)

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Modest Examiner must be notified at

the Maryland

death with

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Exercising ADRE.

altimore, Maryland 21215-0036

Box 68760.

P.O.

of Vital Records,

Division

Hospital or Attending Physician:

the

this After thi funeral of

within 24 hours are: ....
To the Funeral Director: Af

Medical

/Medical

Director

Funeral

þ

Completed

Be

2

Examine The law requires that the death certificate be executed and burial-tran Physician/Medical

aftending physician for use as the buria signed by the a ð Completed nas page 2 s certificate Be Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last IF FEMALE

23b. Was decedent pregnant

9 Unknown

Maccolar 25. Was no

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

1 ☐ Yes 2 ☑ No

in the past 12 months? 1 □Yes 2 ☑No

. Was case referred to medical examiner?

pertension

Thromboy to perua

deg

5 Pending investigation

6 Could not be determined

If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day, Year)

and manner stated.

energetim

Hospital:

Due to (or as a consequence of):

3 Ectopic pregnancy 5 Other (specify) 9 Unknown

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy 1 □ Yes 2 1 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🗆 No

Year

26. Place of Death (Check only one)

A508

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Muluare

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dugel 31. Date filed (Month, Da

7310 32. Reg

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elizabeth McDonough January 8, 2010 ear Ann 5:15 AMMedical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 268-07-9398 1 🗆 M 2 🗓 F Hours February 9, <sup>ar)</sup>1915 Director 94 Kentucky Usual Residence of Decedent shov 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Potomac 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Cliffe Hill Court 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked c Jan John Donovan Mary Sharkey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Tim McDonough / Son 2988 Glenora Lane, Rockville, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 1 🏋 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 12, 2010 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Robert A. Fumphirey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 retex M01305 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Death Months Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Medica. Examiner Due to (or as a consequence of): Coronary Artery Disease 6 Months Sequentially list conditions, in cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Diskrift for as a guneaquenes on novano sician and burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 X No
9 Unknown for Month Day Year page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Atrial Fibrillation Records, Completed 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 1 Yes 2 No Division of Vital or Attending Physician; filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 M Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural 5  $\square$  Pending injury work?
1 Yes 2 No 24 hours after death. Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completed fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nursu Fractioner: To the observe of my knowledge. Seth control at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Morton Kavalier, M.D. 5454 Wisconsin Avenue, Chevy Chase, Maryland 20815

DHMH 17 Rev 7/2009

State Registrar

zabern

32. Regist / 's Sig.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2010 Terencia Ε. January Maduro 1:48 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Hospice Casey House Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 🛛 F Months Days Hours Min. 118-34-3081 67 September 14, 1942 Virgin Usual Residence of Decedent 10a. State U.S. 10b. County Virgin 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No none Christiansted Islands 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 192 Mary's Fancy 00820 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 📉 No 1 Never Married 2 X Married If Yes, Give Year or Dates \$ 1 ☐ Yes 2 No Specify. Black Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Felix Edwards Veronica Fredericks ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3853 Triton Lane, Frederick, Maryland 21704 Quino L. Maduro / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date January 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Fredericksted Public Cemetery 2010 St. Croix, Virgin Islands 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. Myafette Barrata 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01305 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Colon Cancer Months disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last ē Due to (or as a consequence of) Examir Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anemia, Partial Bowel Obstruction 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed Be

and burial-tra P.O. Box 68760, attending physician for use as the buria The law requires that the death certificate be signed by the a Division of Vital Records, page 2 s certificate

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

h and Mental Hygie

Health a

i i i

other

Department of Important; If its any injury or o once.

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at

Certification: To

Medical

29b. Signatur

JAN 1 2 2010

		the state of the s
		24a. Was an autopsy findings available prior to completion of cause of death?  1 □ Yes 2 ☑ No
25. Was case referred to medical	26. P	Place of Death (Check only one)
examiner? 1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐	□ Nursing Home 5 □ Residence 6 ☑ Other (Specify) Hospice
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury Injury  M  28c. Injury at Work?  1 □ Yes 2	28d. Describe how injury occurred 2 □No
3 Suicide 6 Could not b 4 Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 X Certifying Ph	nysician: To the best of my knowledge, death occurred at the time, datt	e and place, and due to the cause(s) and manner as stated.

D47123

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

and manner stated

32. Registrar Signa

29d. Date signed (Month, Day, Year)

January 10, 2010

Joseph Puthumana, M.D. 6001 Muncaster Mill Road, Rockville, Maryland 20855

DHMH 17 Rev 1/2001

Jours after death.

neral Director: After this cr

within 24 hours a To the Funeral D

the Hospital or Attending

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryla		artment of rtificate of		vientai H	ygiene Reg. No. 2 (	010	00372
	Physici		1. Decedent's Name (First, Middle, I Dolores T. Mu					2. Date of D Month	Day	Year 2010	3. Time of Death 7:00 AM
	/Medic Examin Funeral Director	ner	4a. Facility Name (If not institution, g Franklin 500 5. Social Security Number 6. 219–32–2985	rive street and number)  re Hospital	Center s. last birthday) Yrs.	4b. City, Town,  ROSEC  If Under 1 Year  Months Days	If Under 24 Hrs.		4c. Coun Ba irth Day, Year)	ty of Death	Orc lace (State or Foreign try)
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Baltin		City, Town or Lo						0d. Inside City Limits 1 □ Yes 2√ No
	th with the 23a or 28a set by the 1st	Funeral Director	10e. Street and Number 9200 Franklin So	quare Drive		10f. Zip Code	1237		10g. Citizen of USA	What Coun	try?
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Extr. inst. I. ust by truffied at once.	d by Funer	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced	If Yes, Give Year or Dates:	1	I∐Yes 2M∏No		pecify Yes or N o Rican, etc.)	Spec	WII	ite
Delores Maryland 21215-0036	filed within 72 P Hygiene. Ather than "nat	Completed by	15. Decedent's (Specify only highest statementary/Secondary (0-12)	College (1-4or 5+)	(Give life. L	dent's Usual Occu kind of work done OO NOT use retire retary	during most of work		healt	hcare	ustry
Delo	should be fil and Mental H s marked otl umatic ever	To Be	17. Father's Name (First, Middle, La. Howard Philip	Fisher			<u> </u>	eraldir	ne Alleg	rini	
	1 and 2 sh Health and em 27 is n ther traun		19a. Informant's Name/Relationship Donna Becraft/  20a. Method of Disposition	daughter	6838	Leslie	t and Number or Ru Road Balt	imore, M. Date	ber, City or Town D 2122  20c. Location	0	
Saltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spec	cify)		sition (Name of natory or other pla		Date	200. Location	- Oily or To	wii, State
Ba	permi Depar Impor any ir		21. Signalura Funeral Service Lic	1/W	or S	. Name and Addr tate Ana altimore	tomy Boar MD 212	d <sub>1</sub> 655 W	. Balti	more S	
0	Physician /Medical Examiner		23a. Part 1. Enter the disease or co shock, on beart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each line.  a		er the mode of dy	ing, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
68760,	tificate be executed ig physician and as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	C							
P.O. Box 6	at the death certific by the attending p tached for use as i	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	taldeath 3□	Ectopic pregnan Other (specify)	су			ate of delive lonth	ery Day Year
rds, F	w requires that been signed should be det	by P	Part II. Other significant conditions	contributing to death but not re	esulting in the un	derlying cause gi	ven in Part I.	- 10	tobacco use coi  Yes 2 ☐ No		e cause of death? ably 4 Unknown
al Reco	sician; The law requ certificate has been irector, page 2 should	Completed						perf 1 □ Yes	2 Dello	Were autor prior to con death? 1 ☐ Yes	psy findings available inpletion of cause of 2 □No
Ž	Physicia this certi al directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	☐ ER/Outpatien	t 3 DOA Oti	26. Place of Dea ner: 4 ☐ Nursing H		one) sidence 6 □O	her (Specific	/)
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. Attending 10 the Luneral Directors After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Certification: T	27. Manner of Death  1 Natural 2 Accident 5 Pending investigati 3 Suicide 6 Could not determine	be Ose Blees of Injury At	28b. Time of Injury			28d. Describe 28f. Location	how injury occu	rred	
۵	spital or lours afte neral Dir filled in			Physician: To the best of my ki			ime, date and place		own, State)	nanner as st	tated.
	To the Ho within 24 h To the Ful completely	Medical	(Check only one) 2 Medical Example 29b. Signature and title of certifier	aminer: On the basis of examination and manner stated.	nation and/or inv	vestigation, in my	opinion, death occu	rred at the time	e, date and place	, and due to	the cause(s)
	7 wit		> Bine	Sun		Mp. DO			1/2/	2010	
			30. Name and address of person who Binh Nguyen, M	D. 9000 Fr	anklin		Drive F	Saltim	ore, M	D 21	237
	Sta Registr	16	31. Date filed (Month, Day, Year)  JAN 1 2 201	82. Registrar's Sign	ature	2					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** James Markel January 1, 2010 4:30 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner St. Thomas More Nursing Home Prince George's Hyattsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 27, Birthplace (State or Foreign Country) 5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 X M 2 □ F 63 Director 1946 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at Director 1 ☐ Yes 2 ₽ No MD Prince George's Hyattsville 10f. Zip Code 10g. Citizen of What Country? 4920 LaSalle Road 20782 USA Funeral death v unk 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: \$ Specify: 3 Widowed 4 Divorced white Completed Unic LITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) unk unk iink unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be f and Mental I ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health a Important: If item 27 is any Injury or other trau once. 1 and 2 s Health ar St. Thomas More Nursing HOme 4920 LaSalle Road Hyattsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 ☑Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Signature Funeral Service Licensee Director Baltimore, MD 21201

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, cheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final A CITE CIOSCIE NOTIC CARDIOVASCULAR DISEAS **Physician** disease or condition resulting in death) /Medicai Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). burial-transit and Due to (or as a consequence of): nding physician ause as the burial Box 68760. certificate be Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant atten for us 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ Tallux 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Cinoxic anichhalopathy page 1 ☐Yes 2 ☐ No 2 No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Alatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1

DE

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D01852

MIDY 203 Queenshow, Ad Hypothille Mid 207 81

29d. Date signed (Month, Day, Year)

JANUAN 1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G906 8/31/10 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 2nd 2010 10:27 PM langary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Social Security Number anti 8. Date of Birth (Month, Day Ye Jan. 10, 6. Sex Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Year 1955 un<del>known</del> 1 □ M 2 💢 F Months Days Hours Min. Mary Land 54 Director 214-66-1478 Usual Residence of Deced 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination into the traumatic event, the Medical Examination in the individual. 1 □ Yes 🏋 □ No Director MD Baltimore Arbutus 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 918 Circle Drive 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Branch Manager Bank of America 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Scallil Dorothy Marie Byrd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918 Circle Drive, Arbutus MD 21227 Tim Meade - Son 20a. Method of Disposition

Surial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State Geln Haven Memorial 1-6-2010 Glen Burnie, MD 4 Donation 5 Other (Specify)
Signal roof Funeral Service License 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sex /Medical Due to (or a a consequence of): Examiner Due to (or as a consequence f): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-transi and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 2 A No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No within 24 hours after deaun.

To the Funeral Director. After this commietely filled in by the funeral dir 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Decreased in the cause (s) and manner as stated. Decreased in the cause (s) and place, and due to the cause (s) and manner as stated. 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person ause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

			1 - For State Registrar	state of Marylan		artment of F <i>tificate of L</i>			2010	00375
,	Physicis	-m/	1. Decedent's Name (First, Middle, Last)	A		timodio or E	Journ	2. Date of Death	1	3. Time of Death
	Physicia Medic	cal	Marjorie  4a. Facility Name (if not institution, give stree		Newsom			January	6, 2010	11:15 P <sup>M</sup>
	Examir	ner	Holy Cross Hospit				Location of Death r Spring		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 1 Multiple Mult	2 XF 7. Age (In yrs. le	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Sept. 5	Year) 9. Bi	rthplace (State or Foreign ountry) Ohio
	Maryland 18a-f show stified at	rector	10a. State 10b. County MD Prince Geo		, Town or Lo		ttsville			10d. Inside City Limits 1 ☐ Yes 2 No
	n with the l is 23a or 2 nust be no	Funeral Director	10e. Street and Number 1302 Balfour Ct.	-		10f. Zip Code	0782	10	Og. Citizen of What C United St	
9800	e filed within 72 hours after death with the Maryland tail Hygiene. 9d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 ☐ Never Married 2 😿 Married 3 ☐ Widowed 4 ☐ Divorced	Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No f Yes, Give Year or Dates.	H	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🖾 No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
Maryland 21215-0036	ed within 72 ho Hygiene. other than "nai ent, the Medica	Completed by	15. Decedent's Educat (Specify only highest grade co	ion ompleted) College (1-4 or 5+)	(Give k life. Do	O NOT use retired)	ation Juring most of work Assistar	ing	16b. Kind of Business  Education	Industry
yland ;	ould be filed of Mental Hyg marked othe matic event,	To Be	17. Father's Name (First, Middle, Last) Waverly	Ву	rd			e (First, Middle, Ma		-
	2 shou th and 27 is m traum		19a. Informant's Name/Relationship (Type, F Gregory Newsom / Son		19b. Mailin <b>895</b> 8	g Address (Street a Mountain	Ash Ct.,	al Route Number, C Springf	City or Town, State, Zield, VA	ip Code) 22153
Baltimore,			20a. Method of Disposition  1 XXBurial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State	emetery, crem	sition (Name of latory or other place k Cemete	e)		Noc. Location - City of Washington	•
Ball	permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Service Licenses	M0038	ğ	33 Gist	Ave., Sil	<u>ver Spri</u>		0910
ā	Physician/ Medical		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one can Immediate Cause (Final disease or condition resulting in death)	ons that caused the death use on each line.  Due to (conseque	-sul	r the mode of dying	g, such as cardiac o	or respiratory arres	t,	Approximate Interval Between Onset and Death
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09289	cate be executed physician and the burial-transit	edical Examiner	d							
Box 68.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.		in the past 12 months?	f yes, outcome of pregnan  Live Birth 2 Fetal  Pregnant at time of de	death 3	Ectopic pregnance Other (specify)	У		23d. Date of de Month	livery Day Year
ds, P.O.	v requires that to been signed be should be deta	ρ	Part II. Other significant conditions contribu	uting to death but not resu	ılting in the ur	derlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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on of	anding Ph ath. or: After th ne funeral	Certificate:	1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury work?	at 2	28d. Describe how		aryj
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	<b>5</b>		29b. atgnature and the of selltifier	- M	n M	29c. License D	8686	290	d. Date signed (Monti	n, Day, Year)
	7		30. Name and address of person who completed and address of person	In . c		int)	Rd S	werSp	ring MS	20910
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			For State Registrar	State of Ma	aryland .		artment of He tificate of De			giene <sub>Reg. No</sub> 201(	00376
2			Decedent's Name (First, Middle, L.	.ast)	/				2. Date of Dea	neg-ne-	3. Time of Death
	Physicia Medic		Margaret C.	Now con	nb.				Jan.	11, 2010	8:45 A. <sup>M</sup>
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	Funeral			. Sex 7. Age	e (In yrs. last i			If Under 24 Hrs. Hours Min.	8. Date of Birt	th g.B	irthplace (State or Foreign
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	and show	tor	10a. State 10b. County		10c. City, To	own or Loc	cation				10d. Inside City Limits
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	ith the 3a or t be n		10e. Street and Number				10f. Zip Code 21286	:		10g. Citizen of What C	
	eath w	Funeral	1610 Providence 11. Marital Status	12. Was Decedent E	ver in U.S.	13. V	Vas Decedent of Hisp	panic Origin? (Spe	cify Yes or No-	14. Race - Am	nerican Indian,
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Maryland 21215-0036	d 2 shou alth and 27 is m er traum		19a. Informant's Name/Relationship Charles R. New							or, City or Town, State, 2 on, MD 2128	
Baltimore,	permit. Page 1 and in Department of Heali Important: If item any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		cem	etery, crem	sition (Name of natory or other place) ake Crema	)	Jan 12 2010	20c. Location - City of Beltsvil	or Town, State
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Box 687	certificanding pure as	In/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy		Ectopic pregnancy	NI /A		23d. Date of d	elivery
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Vita	nysicia nis cert direct	o B B	examiner? 1  Yes 2 No	Hospital:	ent 2 🗆 ER	l/Outpatien	nt 3 DOA Other	4 Nursing Ho	me 5 Resid	dence 6 Other (Spe	ecify)
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending to completed filled in by the funeral director, page 2 should be detached for use as	Certificate:	3 Suicide 6 Could no 4 Homicide determin		ury - At home c. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Toy	Street and Number or Fi vn State)	ural Route Number,
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										e cause(s) and manner stated.	
_	To the To the Comp		29b. Signature and title of certifier	able	M:	D	29c. License r	number		29d. Date signed (Mor	
	101/		30. Name and address of person w	no completed cause of d	eath (Item 23	Ba) (Type, P	Print)	14.182		1-11-10	<i></i>
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1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 TXNo Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Hospital Cosmetologist 17. Father's Name (First, Middle, Last) Be Albert Thomas Farcosky ည 19a. Informant's Name/Relationship (Type. Print)
Thomas A. Farcosky / Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial ZXXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-9-2010 Atlantic Crematory 21. Signature of Funeral Service Line see Lic # MIM M01537 Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the to for as a nonsequence off and Due to (or as a consequence of) Box 68760. cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 3 🗌 Ectopic pregnancy 5 ☐ Other (specify) ☐Yes 2人No Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ Completed Division of Vital 25. Was case referred to medical examiner? 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Prospital or Attending Property 24 hours after death.
Funeral Director: After to the second property and property at the second property 1/2 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10710 Charter Dr. am 83 DWARD 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Yea **Physician** e sec 2030 M 00 SAN 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 1 F 61 Hours Min. 214-50-9276 Director 1/1/1949 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Nedgal Examinar roust be nother traumatic and injury or other traumatic event, the Nedgal Examinar roust be nother than any injury or other traumatic event, the Nedgal Examinar roust be nother than any injury or other traumatic event, the Nedgal Examinar roust be not the nedgal and injury or other traumatic event, the Nedgal Examinar than the Nedgal MD Howard Columbia 1 ☐ Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11239-A Crystal Run 21044 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status White Specify 16b. Kind of Business/Industry Healthcare 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Evelyn Zabkar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fairway Ct., Severna Park, MD 21146 20c. Location - City or Town, State Glen Burnie, MD 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 48013 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was ... autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Registrar

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 2010 Wer ianuay 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) altimore tunt 5 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 7. Age (In yrs. last birthday) Social Security Number 6. Sex Year) Days Months Hours Min. 1 ☑ M 2 □ F 216-52-1398 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Nes 2 No Hmore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number LISA -len 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2 ☐ MO Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sable 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) wens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rd saltimae, MO 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 16/2010 Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) Howell Juneral Service Lice 22. Name and Address of Facility 21. Signatur Balto MD 21201 Heights 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or a a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 2 No

**Physician** /Medical Examiner Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

Director

by Funeral

Completed

Be

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**Funeral** 

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examination and be notified at once.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar ed by the a signed t has certificate this After t within 24 hours atter death.

To the Funeral Director: A completely filled in by the fu

Physician/Medical

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Completed

Be (

Certification: To

Medical

Division of Vital Records, P.O. Box 68760

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 ☐ Unknown

25. Was case referred to medical examiner?

ŹØNo

26. Place of Death (Check only one)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1∐ Yes

27. Manner of Death

Natural
Accident

3 ☐ Suicide

4 ☐ Homicide

😾 rertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states.

29b. Signature and title of certifier

30. Name and address of person who completed cause of dea h (Item 23a) (Type, Print)

5 ☐ Pending investigation

6 ☐ Could not be

determined

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day,

Yeart

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within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>1</sup>1,20°10 **Physician** JANÜARY **EDWARD** ANTHONY PODOWSKI, SR. 11:50AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RIVERVIEW NURSING FACILITY **ESSEX** BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 8 - 2 7 - 1 9 3 0 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 79 MARYLAND 215-28-1724 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE ROSEDALE 1 ☐ Yes 2 XNo 7 is marked other than "natural", or items 23a or 28a-f si traumatic event, I'm Modical Examinar must be notified Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1309 RUSTIC AVENUE 21237 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian, 1 ∐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 SALES AND SERVICE APPLIANCES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) STANLEY PODOWSKI MATHILDA (GINSKA) ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THERESA M. PODOWSKI/WIFE 1309 RUSTIC AVENUE ROSEDALE, MD 21237 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Surial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 1-15-10 DULANEY VALLEY MEM TIMONIUM, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee ROSEDALE, 1211 CHESACO AVE 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diovaluntar Disease Immediate Cause (Final theroscleratio **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): **Examiner** PHUVIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ned by the a 1 ☐Yes 2 ☐ No 9 Unknown signed by the 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ ongestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy perform 2 X No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier huks Ebo, MD 1/12/10 D61907

of Vital Records, peen has this certificate After of or Attending Fath. Division Director: To the Hospital o within 24 hours aft To the Funeral Di

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I and 2 should be filed within Health and Mental Hygiene. Sm 27 Is marked other than '

Pages 1 and 2 ament of Health a

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State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

hukwuma Ebs, 1124 Mace Avenue, Buetimore, MD 21221
leffled (Month, Day, Year) / 32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician January 9, 2010 Pinsch 7:33 a Joseph /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3901 Sweet Air Road Phoenix Baltimore 8. Date of Birth (Month, Day, Year)
March 22, 1948 Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 M 2 □ F 217-50-6244 61 Luxembourg Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Examiner must be neitlifted an other. Director Baltimore Phoenix 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3901 Sweet Air Road 21131 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sales Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Victor Pinsch Jacqueline Baltes ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Pinsch-wife 3901 Sweet Air Rd., Phoenix, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John 20a. Method of Disposition Date 20c. Location - City or Town, State 1 D Burial 2 ☐ Cremation 3 ☐ Removal from State 01/13/10 Hvdes, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau Mu 1050 York Rd., Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Hypertensia Arterios derotic Lardiovascular Disease
Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) P.O. 9 Unknown s been signed by should be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>Ş</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 □No certificate ha or Attending Physician: director, 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 018667 January 11,2010

Registrar
DHMH 17 Rev 1/2001

State

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Jan 09,2010

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itello, M.D 6 Trimble Hill CT, Lutherville, MD 21093

cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1perPHYS#10c, perFH, 6899, 1/12/2010, WS
State of Maryland / Department of Health and Mental Hygiene
Amend #5, per Fh g900 2/17/10 TT
Certificate of Death

Reg. No. 2 | | 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2010<sub>ear</sub> Day Month **Physician** 6:30 AM Champaben Patel 9 1010 January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil 15 Chesapeake Landing Drive Perryville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan 13, 1931 6. Sex Funeral Days Hours 1 □ M 2 💢 F Jan 548<del>-63</del>-5207 78 Director Usual Residence of Decedent 10c. City Town or Location 1errysville Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10a. State 28a-f shov iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No Director Cecil rrveville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21903 India Funeral 15 Chesapeake Landing Drive 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Asian Indian ğ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 Is marked other than "nature traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Chhotalal Patel Shivacorben Chhotalal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tra <u>Kirit</u> Patel, Son 15 Chesapeake Landing Drive Perryville, MD 21903 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 01/10/10 Baltimore, Maryland Metro Crematory Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home, P.A. Thomas Gregor 301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 214 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Onknown certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an perform 2 No 1 □Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only o e) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral ( 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed carlse of death (Item 23a) (Type, Print) Dr. Angela Popperies 500 Upper Chesapeake Dr Bel Air, MD 21014 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** JAKEINA 09/0/AM 2010 Virginia Pfeiffer /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Glen BYANIN Baltimore Washington Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours Min. 1 □ M 2 1 F 216-20-9184 March 8,1926 Usual Residence of Decedent 10d. Inside City Limits 10h. County 10c. City, Town or Location 10a State 1 ☐ Yes 2 No Director Anne Arundel Severn 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 704 Northwood Estates Drive 21144 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify: White Specify: Ş Q 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Assistant Healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Milton Raymond Waxter Fannie Ella Stallings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs Virginia Atchison/Daughter 704 Northwood Estates Drive Severn MD 21144 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition January 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 14, 2010 Brooklyn Park, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service License Services 1 2 nd Ave. SW Glen Burnie, MD 21061 MONZI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebro VASCULAR ACCIDENT disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months
1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗆 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 DNO Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

the death certificate be executed P.O. Box 68760,

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evandary is ust be motified at

3.2 should be filed within 7 th and Mental Hygiene.
7 is marked other than "1

permit. Pages 1 and 2 s Department of Heatth ar Important: If item 27 is any injury or other trau

Physician

/Medical

Examiner

physician and s the burial-transit

attending pl for use as t

72 hours after death with the Maryland

5-0036

Baltimore, Maryland 2121

PFei FFer,

Division of Vital Records,

certificate has been signed by the rector, page 2 should be detached To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral

funeral director,

State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

my co

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) JANUARY 09,2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Washington Medical Center Battimare Mn T-RANCIS

			1 - For State Registrar	State of Maryland /		e of Death		eg. No. 2010	00383			
	Dhyaiai		Decedent's Name (First, Middle, Last)			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2. Date of Deat Month		3. Time of Death			
- 1	Physicia /Medic		Francis	Andrew	Poteet		January	8, 2010	7:30A M			
	Examin	er	4a. Facility Name (If not institution, give s 702 Whitney's La:			Town, or Location of Death ownsville		4c. County of Death	. 1			
f	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) If Under	1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day,	Anne Arundo	ace (State or Foreign try)			
	Director		220-07-7040	M 2□F 89	Yrs. Months	Days Hours Min.	April 7	,1920	MD			
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location			10	Od. Inside City Limits			
	a-fsh	ctor	MD Anne Aru	ndel Crow	msville				1 □Yes 2 No			
	or 28	Dire	10e. Street and Number 702 Whitney's Lar	odine Dedes	10f. Zip			0g. Citizen of What Count	try?			
	eath w	Funeral Director			210:			U.S.A.	an Indian			
36	be filed within 72 hours after death with the Maryland ttal Hygiene. dd other than "natural", or items 23a or 28a-f show event, I'm Medical Eventing must be notified at	by Fun	11. Marital Status  1 Never Married 2 Married  34 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Agmed Forces? 1/□Yes 2 □ No If Yes, Give Year or Dates:		ent of Hispanic Origin? (S ify Cuban, Mexican, Puerto Dino Specify:	Rican, etc.)	Black, White, e	tc.			
2-0	2 hou natura ical E		15. Decedent's Educ	eation 10	6a. Decedent's Usua	Occupation	vin a	16b. Kind of Business/Ind	lustry			
Maryland 21215-0036	within 72 iene. than "na"	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		k done during most of work e retired)	I					
d 2	filed w Hygie other t	ပ္ပ	17. Father's Name (First, Middle, Last)	5	r. Quality	y Control In		Locke Inst Maiden Surname)	ılator			
an	should be nd Mental marked o	To Be	Joseph Poteet			Elizab	eth Gras	ser				
lary	2 shot and N is ma		19a. Informant's Name/Relationship (Typ			(Street and Number or Ru	ral Route Number	r, City or Town, State, Zip	Code)			
	1 and Health em 27 ther to		Mrs Betty C. Elswin		Cliffe Court	Data	a MD 21122  20c. Location - City or Tox	wn State				
Baltimore,	nit. Pages 1 and 2 should artment of Health and Mer ortant: If item 27 is marke Injury or other traumatic 8.		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	e of Disposition (Nametery, crematory or other), and Vets.	Cem. 14,	2010	Crownsville	e, MD			
Ball	permit. Departr Importa any Inju		21. Signature of Funeral Service License	teel MO159	27.11	d Address of Facility Sizes PA 1 2nd .						
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the death. Decays a cause of a caus					Approximate Interval Between Onset and Death			
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7	Examiner											
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Vital Records,	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. Within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Completed					24a. Was a autops perforr 1 □ Yes	by prior to condeath?	osy findings available inpletion of cause of 2 No			
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sion	Attending ir death. ector: After by the fune	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day, Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No						
Division of	tal or At rs after d al Direct led in by	Certification:	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, factory,	office	28f. Location (St City or Town	treet and Number or Rura n, State)	l Route Number,			
1	the Hospital or hin 24 hours afte the Funeral Dir Tpletely filled in I	Medical		ician: To the best of my knowled ler: On the basis of examination and manner stated.								
	To the within To the сотр	Me	29b. Signature and title of certifier		29c.	. License number	2	9d. Date signed (Month, I	Day, Year)			
			MC Van	ico on	7	000623	01	8 Jan,	(0)			
			30. Name and address of person who co	mpleted cause of death (Item 23a	a) (Type, Print)	£ 808 T-	G1	en Burnie, l Prive Suite	MD 21061			
V.	Stat	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	-0 , /	000 110	L. C. L.	TIVE DUILE	140			
1	Registra	ar	JEAN I Z ZHIN		1							

DHMH 17 Rev 1/2001

		-	For State Registrar	State of Mary			nt of He e <i>of D</i> e		lental Hy	giene Reg. No		1.0	00001
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Λ.			ath Da	20	<del>I U</del> Year	3. Time of Death		
Medical			Alice 4a. Facility Name (if not institution, give stre	Phill	Lips Ja 4b. City. Town, or Location of Death			Januar	Inuary 9, 2010 4:50 A			L 4:50 A <sup>M</sup>	
Examiner			Presbyterian Home	oct and nambor,		Towson			Baltimore				
	Funeral Director		5. Social Security Number 6. Sex 1 $\square$		yrs. last birthday) 90 Yrs.	If Unde Months		If Under 24 Hrs. Hours Min.	8. Date of Bir April D	th ly, Year)	919	9. Birthp Mary	lace (State or Foreign $\Upsilon$ and
	now at	ī	Usual Residence of Decedent  10a, State 10b. County	10	c. City, Town or L	ocation						1	0d. Inside City Limits
relyneM odt	arylar 3a-fsk ified a	Funeral Director	Maryland none		Baltim	ore							1 🎇 Yes 2 🗆 No
	a or 28	Ö	10e. Street and Number		-	10f. Zi	p Code			10g. C	itizen of Wi	nat Coun	try?
	ns 23 must l	nera	28 N. Bond Street				21231		N		ted		
030	outo be filed within 72 hours after death with the way yand do Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "dedical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	<ol> <li>Was Decedent Ever Armed Forces?</li> <li>□ Yes 2 X No If Yes, Give Year or Dates.</li> </ol>	in U.S. 13.		dent of Hisp cify Cuban, 2 🛣 No	panic Origin? (Spe Mexican, Puerto Specify:	Rican, etc.)		14. Race Black Specify:	, White, e	
3500-GLZ	"natu "natu edical	plet	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	kind of we	al Occupati ork done du	ion ring most of work	ing	16b. h	Kind of Bus	iness Inc	lustry
121	ene. r than	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	I .	oo not us c <b>eria</b>	e retired) Manag	ger		Co	unty	Sch	001
Maryland 21	al Hygi I other vent, 1	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle				
<u> </u>	Mental Mental arked c	욘	Grandville Kinsey					Elizabe		<u> </u>			
ĭ Za	alth and alth and 27 is n er traum		19a. Informant's Name/Relationship (Type, Albert Eugene Phil			-		d Number or Rura eet, Bal					
Jore,	age 1 an ant of He art: If item		20a. Method of Disposition  1 X Burial 2 Cremation 3 Re	emoval from State	20b. Place of Disp cemetery, cre Arlington N	matory or	other place)	Janua	ary 19,		ocation - 0		
Baltimore,	permit. Page 1 and 2 should be I Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev		4 Donation 5 Other (Specify)  Arlington National Cemetery 2010 Arlington, Virginia  21. Signature of Fune/al Service Licensee  22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockyille, Inc.										
	462 60	Н	23a. Int 1 of ter the disease, or complic	ations that caused the							e, Mary	Land	Approximate
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Division of Vital Records, P.O. Box 68	requires that the death cefuir been signed by the attending should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unkn									ery Day Year	
Ö.	ed by t detach	y Phy	Part II. Other significant conditions cont	ributing to death but r	not resulting in the	underlying	cause give	n in Part I.	23e. Did	tobacco	use contrib	oute to th	ne cause of death?
ds, F	quires tr en signi uld be	ed by							1 🗆	Yes 2	No :	3 🗆 Prob	oably 4 🗆 Unknown
3ecor	ine law red ate has bed bage 2 sho	Completed	24a. Was an autopsy performed?								pi	ere autopsy findings available for to completion of cause of eath?	
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<u> </u>	Pnysi rthis c ral dire	2	1 ☐ Yes 2 🖾 No Ho  27. Manner of Death	1 Inpatient 28a. Date of injury	2 ER/Outpati		28c. Injury a	4 Nursing He	ome 5 Res 28d. Describe				)
ono .	anding sath. or: After	ficate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Yo	ear) injury	М	work?	es 2 □ No	Zod. Beschibe flow injury decurred				
Divisi	In the hospital or Attending Priysician; The law requires that the beam within 24 burs after death.  Within 24 burs after death.  Completed filled in by the funeral director, page 2 should be detached for a completed filled in by the funeral director.	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	ry, office	City or Town, State)								
:	ne Hosp in 24 ho ne Fune pleted fi	Medical	29a. Certifier 1 Certifying Physici (Check 2 Medical Examine only one) 3 Certifying Nurse I	r: On the basis of exan	nination and/or inve	estigation, in	my opinion	, death occurred a	t the time, date	and plac	e, and due	to the ca	use(s) and manner stated.
	Voith To ti	200 Liganos number							29d. Date signed (Month, Day, Year)  January 10, 2010  Life 4104 Balthain, mol 21204			Day, Year)	
			30. Name and address of person who con Kenneth M. Gra		h (Item 23a) (Type 670)	Print) N.C	Lades	54.,54	704/10	1 4	Salti	h, sie	m0 21204
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's									

DHMH 17 Rev 7/2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10, Timothy James Ouinn 2010 January 8:10 P. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🙀 M 2 🗆 F Months Days Hours Min. 56 Director 217-62-7258 Missouri Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Maryland 1 Yes 2 XNo Cecil Elkton (1997) 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 239 E. Main Street 21921 USA er than "natural", or items the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. ģ 1 Never Married 2X Married 1 ☐ Yes 2 🗶 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry Je filed with Teal Hygiene. Tear than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) IARC Northern Chesapeak Region 5+ Executive Director marked other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H 7 is marked o ဂ္ဂ Edward Francis Ouinn Mary Jayne Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sof Health Mrs. Gloria M. Quinn (Spouse) 239 E. Main Street Elkton, Md. 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of IImportant: If ite any injury or ot Burial 2 Cremation 3 Removal from State Dulaney Valley Mem. Gdns. 4 Donation 5 Other (Specify) 1/14/2010 Timonium Maryland 21. Signature of Finera 22. Name and Address of Facility 21204 Towson, Md. Ruck Towson Funeral Home, Inc. 1050 York Road Part 1. Inter the dise set or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 42NS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed ending physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 Yes 2 No Month Pregnant at time of death Day Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performet 1 Yes 2 No 2 🗀 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Yes 2 No Director: A Accident Investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Box 68760 Records, P.O. Hospital or Attending Physician: The Division of Vital hours

completed filled in by To the Funeral within 24

Medical

(Check

only one) 29b. Signature and title of certifi

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

- TOW SON MO

2010

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January Physician/ 4:45 Walter H. Reichert, Sr 8,2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Ye April 25 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □XM 2 □ F Min. Hours 213-28-7143 Maryland 79 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore 1 🗆 Yes 2 🗓 No Parkville 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 2900 Onyx Road 21234 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 2 Yes 2 1 No Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give white Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County Police Officer 12 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ is marked Muriel Thompson Frank Carl Daniel Reichert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter H.Reichert, Jr-son 1706 Glen Curtis Road-Essex, Maryland 21221 mportant: If item 27 Page 1 and 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
inity Lutheran
irch cemetery Department of 1 Neurial 2 Cremation 3 Removal from State Jan.11,2010 Joppa, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Evans Funeral (
800 Harford F Chapel and Cremation Services Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, physician and s the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth Z L 1 sea Pregnant at time of death ate has been signed by the atte page 2 should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No. the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 X Other (Specify) **HOSPICE** ပ္ 1 Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury X Natural 5 Pendina after death. 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the 6 3 🖫 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of

DHMH 17 Rev 7/2009

State

Registrar

JACKIE JONES,

JAN 1 2 201

31. Date filed (Month, Day, Year)

2010

JANUARY

WALTER REICHERT

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

ss of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:50 PM Nancy Sue Roberts 01 07 2010 /Medical 4c. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1 DE ICAN If Under 1 Year | If Under 24 H Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 🗙 F Yrs 80 7, 1929 Director 277-26-4736 Feb. Ohio Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mental Hyglene. ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ortant: If item 27 Is marked other than "natural" or items 25a or 28a-f show luly no rother traumatic event, the Medical Examiner must be notified at 10d Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2XINo Directo Harford Abingdon Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21009 United States 2732 Merrick Way Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify:White Baltimore, Maryland 21215-0036 Specify. þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Broadcasting Receptionist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary McKinnon John C. Boldon P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2732 Merrick Way Abingdon, Maryland 21009 Karen Crane / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Evans Funeral Chapel 01/11/2010 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department or Important: If any Injury or Bel Air Forest Hill, Maryland 22. Name and Address of Facility
Evans Funeral CHapel & Cremation Service—BelAir
3 Newport Drive Forest Hill, Maryland 21050 21. Signatur / Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COVOIN Almora Due to (or as a conse lience of) /Medical **Examiner** Toronguy Sequentially list conditions, if any, leading to infinite date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗷 No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 20 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 2 No Division or Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 410 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M MM

ROBERT

NANCY

State

22. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 1 2 2010

11 clive im

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

colonil ad Mel Aw. Mnd1014

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygier  1 - State Registrar  Certificate of Death  Reg.									20	10	001	2 0 0				
			Registrar  1. Decedent's Name (First, Middle, Last)		Cei	inicate or L	- Call	2. Date of Dea		LU.	3. Time of	Death				
Physician Medica			Linda 1	Monroe	Ross			January	y <sup>Day</sup> , 2	2ďTo	1:17	Рм				
Examiner			4a. Facility Name (if not institution, give street and number	r)		4b. City, Town, or			4c. County							
- 1	10000 Brunswick Avenue  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)					Silver	Spring		gomer	y place (State o	- Famian					
	Funeral Director		377-64-0035 1	55	Yrs.	Months Days						Foreign				
15	T on		Usual Residence of Decedent  10a, State 10b. County	10= 0	y, Town or Lo						04 1-14-05	L. I izalia				
	aryland a-f sh fied a	cto	Maryland Montgomery	Too. City		r Spring				,	0d. Inside Ci	2 X No				
	or 28	Dir	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour		77				
	s 23a	Funeral Director	10000 Brunswick Avenue			209	10		United	Stat	es					
9800	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Dates	s? X No		Vas Decedent of Hi f Yes, specify Cuba Yes 2 🗶 No		Specify Yes or No- rto Rican, etc.)		ce - Americ ck, White, e	etc.					
21215-0036	within 72 hou giene. Ier than "nati It, the Medica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4) 5+	or 5+)	(Give life. D	lent's Usual Occupa kind of work done d O NOT use retired) Producer	uring most of w		16b. Kind of B		•					
d 2	filed w al Hygi d other event, t	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle,								
ylar	id be f Menta arked aric ev	욘	George C. Ross				Madele	ine Ric	h							
Maryland	1 and 2 should be file of Health and Mental R f item 27 is marked o r other traumatic eve		19a. Informant's Name/Relationship (Type, Print)		1	ng Address (Street a				-		·				
	and 2 Health tem 27 other to		Ann E. Kovatch / Daughten  20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of	1	Date	20c. Location							
ош Ш			1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from St. 4 ☐ Donation 5 ☐ Other (Specify)	ate C6	emetery, cren	natory or other place Crematorium	) Jan Inc 20	uary 12, 010	Bethe	•		nd				
Baltimore,	permit. Page Department Important: I any injury or		21. Signature of Funeral Service Licensee	M0130	5 Ro	Name and Address bert A. Pun 57 Wisconsi	s of Facility iphrey Fur n Avenue	neral Home/ Bethesda,	Bethesda Maryland	-Chevy   20814	Chase, -3501	Inc.				
			23a. Part 1/Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between													
-	h, sician/		Immediate Cause (Final disease or condition Complications of Multiple Sclerosis								ears	)eath				
1	Physician: The law requires that the death certificate be executed  The second of the		resulting in death) Due to (or	as a consequ	uence of):											
		ner	Sequentially list conditions, if any, leading to immediate Due to (or	b. Due to (or as a consequence of):												
		Examiner	Cause. Enter Underlying Cause (Disease or iinjury that initiated events  c							_						
		alE	resulting in death) Last  Due to (or as a consequence of):  d.													
760		by Physician/Me	by Physician/Me	by Physician/Me	by Physician/Me	d										
Box 687						þ	þ		th 2 ☐ Feta nt at time of d	al death 3	Ectopic pregnanc Other (specify)	у			ate of delive onth	•
s, P.O.	v requires that the sbeen signed by should be detact							þ	Part II. Other significant conditions contributing to deat	:h but not resi	ulting in the u	nderlying cause giv	en in Part I.		obacco use con Yes 2 🕅 No	
of Vital Records,	w requ	Completed						24a. Was		Were auto	psy findings a	ause of				
Rec	The law arte has page 2 s	Som						perfo	rmed? 2 X No	death? 1 🗌 Yes						
tal	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?  1 X Yes 2 No  Hospital:			26. Pla	ace of Death (Ch									
Ţ	Physic this cral dir	2	1	patient 2  injury	ER/Outpatier 28b. Time of	it 3 🗆 DOA	4 ☐ Nursing	Home 5 K Resid			)					
o uc	Attending or death.  Botor: After by the funer	icate	1 X Natural 5 Pending (Month, Day, Year) injury				y at 28d. Describe how injury occurred k? I Yes 2 □ No									
Division	r Atte ter de irecto ir by th	ertif	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Ö	Hospital o		Continue 1 X Continue Division To the hear	t af an Impud	lades dasta	annual at the time	date and place	and due to the an	(a) and man							
	To the Hospital or Attending Phy within 24 hours after death.  To the Funeral Director. After this completed filled in by the funeral	Medical	29a. Certifier 1 Certifying Physician: To the besis (Check 2 Medical Examiner: On the basis only one) 3 Certifying Nurse Practions To	of examination	n and/or inves	tigation, in my opinic	n, death occurre	d at the time, date a	nd place, and du	ue to the car	use(s) and ma	nner stated.				
	Vithir comp	2	29b. Signature and title of certifier								ate signed (Month, Day, Year)					
			1 (des //gl		_	D005	8994		Januar	y 11,	2010					
_				ecutiv	e Blvo	Print)	00, Rocl	kville, M	laryland	2085	52					
	Sta Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature													

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Day **Physician** ROBINSON dryany 08 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner al Dre 0 If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1**√** M 2□ F Months Days Hours Min Director 76 So. Carolina 247-46-7208 Mar 10, 1933 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shifted Wedical Examinet Frust be notified. Yes 2 No Director **Baltimore Baltimore City** Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 1103 Kevin Road 21229 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1√7es 2□No If Yes, Give Year or Dates: 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1952 1 ☐ Yes 2 😿 No Specify Black 3 Widowed 4 Divorced 1955 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **BGE** Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If item 27 is marked or any Injury or other traumatic eve Beatrice Robinson Henry Robinson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1103 Kevin Road Baltimore, Maryland 21229 Mary Robinson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 ment of h 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 01/15/10 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) **Baltimore National Cemetery** 21. Signature of Furneral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in eart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** +40 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform this certificate 2 1 No 1 ☐ Yes 2  $\square$  No 1 □ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \(\subseteq\) Nursing Home \(\subseteq\) S \(\subseteq\) Residence \(6 \subseteq\) Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY Q 00 PM Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Hmore 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** Month, Day, Days Hours Min 1 🗆 M 2 🛂 Months Yrs Director or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Medical Examiner must be notified 1 Ves 2 No TIMORE 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' Black, White, etc. ò 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mential Hygiene. Important I fiem 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 ☑ No Specify Slack 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) /Seconday (0-12) College (1-4 or 5+) sab Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Són 46 Merdi Dallalas 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 18 2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signatur uneral Service Li ht 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) cate has been signed by the attending physician a page 2 should be detached for use as the burial: Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Pregnant at time of death Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? after death.

Director: After this certificate! 1 Yes 2 🗌 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) To the Hospital or within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 10043375 MixIN 2010 WA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE STE 203 BALTIMOLE 2835 METULIT SHITH 31. Date filed (Month, Day, Year) State Registrar

10-00035							
Rodger Stith							

ger Stith		1- For State	of Maryland / Depart	tment of H		Mental Hy		20	10 0039	
Physici dical Exami		1. Decedent's Name (First, Middle,Las	1)	-			2. Date of Death	Day Year	3. Time of Death 1219 hrs	
		4a. Facility Name (if not institution, give Mercy Medical Center	e street and number)	i i	City, Town, or Lo altimore	ocation of Death		4c. County of	Death	
Funeral Director		5. Social Security Number 6. Se 240 94-7634 17			Under 1 Year Months Days	If Under 24Hrs Hours Min.	8. Date of Birth	<i>i</i> 1	9. Birthplace (State or Foreign Country)	
land f show any once.	or	10a. State 10b. County		own or Location 2 HiMOV					10d. Inside City Limits 1 Yes 2 No	
ith the Maryland 23a or 28a-f show	Il Director	10e. Street and Number 5721 Onnen R			f. Zip Code 2/2			g. Citizen of Wha	7	
death wi	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	If Yes, s	pecify Cuban, No	anic Origin? (Sp Mexican, Puerto specify:	Rican, etc.)	White,	Black	
nore, MD 21215-0036 ges 1 and 2 should be filed within 72 hours after nt of Health and Mental Hygiene.  11: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner.	Completed	15. Decedent's Education (Specify or Elementary/Secondary (0-12)	lly highest grade completed) 1 College (1-4 or 5+)	6a. Decedent's U during most of Care Ho	of working life. D	OO NOT use retir	ed)	Rehabi	litatim Cente	
D 21215-00; should be filed within and Mental Hygiene, 7 is marked other til	To Be Co	17. Father's Name (First, Middle, Last) William Stith  19a_Informant's Name/Relationship (T	ype, Print )	19b. Mailing Add		Mollie	(First, Middle Ma	rower	State, Zip Code)	
re, MD s 1 and 2 sho f Health and If item 27 is cr traumati		Thunda Edmor  20a. Method of Disposition  1 Naurial 2 Cremation 3	20b. Pla	5121 0 ace of Disposition ematory or other p		Road etery,	KW + 1	4672 / 20c. Location - C	ary land 2120 City or Town, State	
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other ti	ļ	4 Donation 5 Other Specify: 21. Signature of Fune al Service Licen:	Ga	YYI SIX	and Address of	f Facility	1110   119-121	Owings 1	Yills Ma	
Physician /Medical		23a. Part I. Enter the disease, or comp failure. List only one cause on ea					respiratory arres	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Approximate Interval Between Onset and Death	
Examiner		or condition resulting in death)  Sequentially list conditions,  b.	Due to (or as a consequence of):	0.10 001010		иос сопірно	ated by Hype	, and an an an an an an an an an an an an an		
red     nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of):							
60, te be executed ysician and burial - transi	ledical	UNPENDED	AMENDED					22d Date of d		
Box 68760 e death certificate b the attending physi	siciar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnar  1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal d	eath 3	Ectopic pregnal	ncy	23d. Date of d	Day Year	
, P.O. Bires that the disigned by the	d by Phy	Part II. Other significant conditions	significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco						o use contribute to the cause of death?  No 3 Probably 4 V Unknown	
of Vital Records, P.O. Be g Physician: The law requires that the de riter this certificate has been signed by the meral director, page 2 should be detached?	Completed		-				24a. Was an autopsy perform	pri ed? de	ere autopsy findings available or to completion of cause of ath?  Yes 2 No	
/ital   ysician: his certifi director,	o Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2 🗸 EF	R/Outpatient 3[		Death (Check of ther)		esidence 6	Other:	
C # _ \ 2	cation: T	27. Manner of Death  1 Natural 5 Pending Investigation   28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury at Work?   28d. Describe how injury occurred   Subject exposed to below freezing   28d. Describe how injury occurred   Subject exposed to below freezing   28d. Describe how injury occurred   Subject exposed to below freezing   28d. Describe how injury occurred   Subject exposed to below freezing   28d. Describe how injury occurred   Subject exposed to below freezing   28d. Describe how injury occurred   28d. Describe how injury occ							freezing es	
Division Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	Certifi	or Town, State					te)	out Avenue, Baltimore, MD		
To the Hos within 24 h To the Fur completely	edical	one) 2 Medical Examiner	an: To the best of my knowledge, On the basis of examination and/ and manner stated.	, death occurred a /or investigation,	in my opinion, d	eath occurred a	the time, date ar	nd place, and due	e to the cause(s)	
	Ž	29b. Signature and title of certifier	M, Mo		O.C.M.			January 3, 2	(Month, Day, Year)	
		30. Name and address of person who of Melissa Brassell, MD As	ompleted cause of death (Item 23 sistant Medical Examine		Street, Bal	timore, MD	21201			
St	tate	31. Date filed (Month, Day, Year)	32 Registrar's Signature	1 .		<del></del>				

DHMH 17 Rev 1/2001 OCME 2006 OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3:10 A M Medical 4c. County of Death
Rallimor Examiner 4b. City, Town, or Location of Death Timonium 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 **M** M 2 □ F Hours Min (Month, Day Director items 23a or 28a-f show 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No 10g. Citizen of What Country? Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) Be 18. Mother's Na<u>me (First, Middle, Maiden Surname</u>) Vane er or Rural Route Number & 20b. Place of Disposition (Name of cemetery, crematory or other 1 Burial 2 Cremation 3 Removal from State Other (Specify) Fignature of Funeral 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) PROSTATE CANCER Medical Examiner Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) and that initiated events resulting in death) Last Due to (or as a consequence of) burial-t inding physician use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 s been signed by the attending I should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an his certificate has b I director, page 2 sh autopsy Yes 2 X No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2X No ည 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral dir 4 Nursing Home 5 Residence 6 X Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? \_\_1 ☐ Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending iniury X Natural 2 🗌 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year) person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 JONES.

DHMH 17 Rev 7/2009

State Registrar

2010

JANUARY

GEORGE SWEETWINE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00394 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 339 Jobert TAN 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DMORE Skoodmead Year I If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Year) 1 2 M 2 □ F Months Days Hours Director 160-10-1809 niledelphia PH Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 No Issaguar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Funeral or items 23a PMB #26 12. Was Decedent Ever in U.S. Armed Forces? 1 Ares 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify <u>ک</u> Specify: 3 Widowed 4 ☐ Divorced is marked other than "natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Dept. of Elementary/Secondary (0-12) College (1-4or 5+) onomic Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ leight niami 19b. Mailing Address (Street and Number or Rural Route Number, City or Youln, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra once. 12 33 20c. Location - City or Town, State Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 12 permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 6924 RD. MONCTON MODILL 23a. Parl 1. Enter the disperse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart felture. List only one cause on lach line. Approximate Interval Between Onset and Death Immediate Cause (Fin Physician Sta disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of Ir jury that initiated events Due to (or as a consequence of): Examine requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical 687 the Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) o 1 ☐ Yes 2 ☐ No 9 Unknown cate has been signed in page 2 should be detailed. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Record 24b. Were autopsy findings available prior to completion of cause of death? Attending Physician: The law 24a. Was an certificate has autopsy performe Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 17 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ŏ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 🗀 Yes 2 🗀 No after death 2 Accident ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide ö 24 hours a Funeral L 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) To the 4 within 24 To the F and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

led (Month, Day, Year)

0

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. / 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Ira Reeder Sheckells, Sr. Day 23:10 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Good Samaritan Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days July 11. 1 X M 2 □ F Months 220-18-4869 83 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits with the Maryland Director ms 23a or 28a-f s must be notified Baltimore 1 X Yes 2 ☐ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a e Funeral 2515 Hermosa Avenue 21214 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No WW Ⅲ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married e filed within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates per it. Page 1 and 2 should te filed within 72 hours. Det artment of Health and Mental Hygiene. Important: If item 27 is maried other than "natur any injury or other traumatic event; the Medical sone. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Jewel Tea Inc. Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Sheckells Rosie Balderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Sheckells/ Wife 2515 Hermosa Avenue, Baltimore, Maryland 21214 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 01/13/10 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee War Andrea Fritapel & Cremation Services 800 Harrord Rd. Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ASPIRATION Physician/ PNEUMBNIA di ease or condition sulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) Cause (Disease or iinjury that initiated events resulting in death) Last sate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Day Pregnant at time of death Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ End steep Renal chi seuse 1 Yes 2 No 3 Probably 4 Unknown Completed Arter Caronan Disease 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page 2 🗌 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 ☐ Yes 2 ☑ No ပ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: Natural
Accident
Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 🕯 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) mens 23986 UMPS 01,09,2010

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DHMH 17 Rev 7/2009

Registrar

Mohan Rudrappa, 5601 Loch Eaven Blud Good Samardan Hospital, Ballmore MD 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

JAN 1 2 2010

31. Date filed M

10-00297 Matthew Joseph	Sal		r Print in Black Ind					egible.	
Matthew Joseph		1- For State Registrar	of Maryland / Depar <i>Certi</i>	iment of ificate of		io ivientai n		201( Reg. No.	00396
Physicia Medical Examir	ın/ ner	<ol> <li>Decedent's Name (First, Middle, Last Matthew Joseph</li> </ol>	Salafia				2. Date of De Month January	ath	3. Time of Death 2318 hrs
)		<ul><li>4a. Facility Name (if not institution, give</li><li>10 East Mulberry Street</li></ul>	e street and number)		b. City, Town, o Baltimore	or Location of Deat	h	4c. County of Death	1
Funeral Director			x 7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Ye		_	irth(MM/DD/YYYY) 9. Bir Foreig	
Maryland 28a-f show any 1 at once.	'n	Usual Residence of Decedent  10a. State		own or Locati					10d. Inside City Limits  1 Yes 2 X No
n the Maryla 3a or 28a-f	Director	10e. Street and Number 1509 Sherbroo	k Road		10f. Zip Code 2109	)3		10g. Citizen of What Cou	ntry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	es, specify Cuba	and the second second	Rican, etc.)	White, etc.	ican Indian, Black, White
1036 vithin 72 hours er than "natur Medical Exam	Be Completed k	15. Decedent's Education (Specify on Elementary/Secondary (0-12)	ly highest grade completed)  College (1-4 or 5+)  5+	during mo			ired)		_aw Offices
215-0 e filed w tal Hygic ked othe		17. Father's Name (First, Middle, Last) Nicholas Salafia					e (First, Middle, Owens	Maiden Surname)	_
AD 21; 2 should b h and Men 27 is mar imatic eve		19a. Informant's Name/Relationship (Ty Mari Salafia/ Wi			•			mber, City or Town, State	
nore, hages I and nt of Healt it. If item other trau		20a Method of Disposition  1 Burial 2 Cremation 3	Removal from State cre	ace of Disposi ematory or oth	tion (Name of ce	emetery,	Date 5/2010	20c. Location - City or Timonium,	Town, State
Saltin Permit. P Departme Importan		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licens		22. N	ame and Addres	s of Facility		Maryland 212	
Physician	- 4	23a. Part I. Enter the disease, or compl failure. List only one cause on ear						, Inc. 1050	Approximate Interval Between Onset and
/Medical Examiner			Contact Gunshot Wound  Due to (or as a consequence of):	of Chest					Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):						
ecuted and transit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			_			
be executician and	dical	UNPENDED	AMENDED						
	sician/I	IF FEMALE: (3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna  1 Live birth 4 Pregnant at time of 9 Unknown	2 Fet	al death 3 er (Specify)	Ectopic pregna	ancy	23d. Date of delivery Month	day Year
5, P.O. B ires that the de 1 signed by the	2	Part II. Other significant conditions	contributing to death but not resu	ulting in the ur	nderlying cause	given in Part I.		tobacco use contribute to	
Division of Vital Records, tal or Attending Physician: The law requirers after death all Director: After this certificate has been siled in by the funeral director, pagr 2 should be in by the funeral director, pagr 2 should	Completed								topsy findings available ompletion of cause of
Vital Rec	å	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2 E	P/Outnationt		e of Death (Check		Pasidence 6 10 Other	Scana
n of Vii ding Physia n : After this	on: To	27 Meson of Double 290 Details and John Model 2 290 Describe how injury constraint							. ocene
Divisior pital or Attend ons after death teral Director:	ertification:	Accident  Accident  Accident  Suicide  Homicide  Accident  Suicide  Accident  Accid							
To the Hospital within 24 hours to ompletely filled	ल	one) 2 Medical Examiner:	n: To the best of my knowledge On the basis of examination and						
To To con	Mec	29b. Signature and title of certifier	and manner stated.	1	29c Licens		OCME	29d. Date signed (Mon	
20 v	+	30. Name and address of person who control of the c			1 111 Penn St	treet, Baltimor	e, MD 2120	1	
Sta Registr	11.0	31. Date filed (Month, Day, Year)	32. egistrar's Signature	bar	del				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 5, 2010 Judy Nannette Schleig 3:50 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 204 Brookside Drive Catonsville Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. . Social Security Number 8. Date of Birth Date of Birth (Month, Day, Year) 3 19<u>32</u> 9. Birthplace (State or Foreign **Funeral** 233-48-3677 1 M 2 TYP Months Days Min. West Virginia Director Aug Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Baltimore Catonsville 1 Tyes 2 XNo 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 204 Brookside Drive 21228 United States Was Decedent Ever in U.S. Armed Forces 1 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 lead Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Broker Mortgage Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Pauline Keener Herschel Belt 19a. Informant's Name/Relationship (Type, Pnnt)
Candace Ratliff - Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 Brookside Drive, Catonsville, MD 21228 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of Cremster), clergatory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Memorial Gardens 1-8-2010 Marriottsville, MD 22. Name and Address of Facility Signatur Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betwee Onset and Death Immediate Cause (Final CARCINOMA OF THE Physician/ METASTATIC MONTH disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 After this certificate has been signed by the attending funeral director, page 2 should be detached for use as IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred al or Attending P s after death. I Director: After t 1 🔀 Natural 5 Pending injury work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed caus of death (Item 23a) (Type, Print) MAN)MY STAGNES HOSP 900 S CHATON ANE BACTOMD 2149 32. Regi

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 For State Registrar 00398 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 8 ay 2018 7:10 a M Inez Virginia Sams Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore 30 North Chester Street n/a 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Days Jan 30. 218-36-5395 Months Hours Min. **"**938 **Director** MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD n/a Baltimore 1 ¥ Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 30 North Chester Street 21231 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 X Never Married 2 Married ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Floor Supervisor Venture Plastic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Loney Bedsworth Elizabeth Gladden item 27 is marke other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Kauffman-Sister 30 N. Chester St. Baltimore, MD 21231 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site Crematory 1.12.2010 |Baltimore, MD Sign ture of Furieral Service Lice John L. Williams Funeral Directors, 4517 Park Heights Ave Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ man disease or condition resulting in death) , Medical Due to (or as a consequence of Examiner eas Sequentially list conditions, Examine Due to (or se a consequence of) cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Cause (Disease or iinjury burial-tran sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? this certificate 1 ☐ Yes 2 🔀 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State

(Check

only one)

Signature and title of certifier

301

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of

ST.

Than from, mi

+ au

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

57088

Bartimery, m)

29d, Date signed (Month. Dav. Year)

11

2010

JANUARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decadent's Name (First, Middle Last 2. Date of Death Physician/ Month 0mp501 12. OXM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b\_City, Town, or Location of Death 4c. County of Death (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign Country) M 2 □ F Months Hours Min Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tiem 27 is marked outher than "natural", or items 23a or 28a-f show important: If tiem 27 is marked outher than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 115A Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubap Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married Black, White, etc. þ Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates. 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0412) College (1-4 or 5+) Be ner's Name (First, Middle, Last) <u>ە</u> nformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) Baltimore, Method of Disposition Place of Disposition (Name of demetery, crematory or other p 20h 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licenses 22. Name and Address of Facili 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he if failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to or as a conse Lence of The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and Due to (or as a consequence of) Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Unknown Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabeks Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has within 24 hours after death.

To the Funeral Director: After this certificate 2  $\square$  No 1 🗌 Yes Hospital or Attending Physician: director, 25. Was case referred to medical of Vital æ 26. Place of Death (Check only one) examiner? Certificate: To 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? Division 2 🗆 No Investigation 6 Could not be Suicide 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) 056211 wh

State Registrar

DHMH 17 Rev 7/2009

20000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

rw, N, MO

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-00197 State of Maryland / Department of Health and Mental Hygiene Christopher Tubiolo 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Christopher 2239 hrs Medical Examiner Tubio1o January 7, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Montgomery 7416 Hancock Avenue 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of 8irth(MM/DD/YYYY) 9. 8irthplace (State or 6 Sex **Funeral** 213-06-0504 1 M 2 F Months Davs Hours Min Director Country) Maryland 05/03/1967 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 1 X Yes 2 No MD Montgomery Takoma Park 28a-f show death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7416 Hancock Ave. 20912 United States Funeral 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married White imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after or near of Health and Mental Hygiene. Yes, Give Year 1984-86 3 Widowed Divorced Yes 2 X No specify: Specify the Medical Examiner ۾ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 6b Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Building 12 Electrician Construction 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Joseph Tubiolo Ellen Ridgeway event, Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Lucille Madert / Sister 1001 N. Mansion Dr., Silver Spirng, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date timore, crematory or other place) Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 1/12/2010 Beltsville, MD ment c Donation 5 Other Specify 5 22 Name and Address of Facility
Rapp Funeral and Cremation Services 21. Signature of Fu eral Service Licenses 0910 933 Gist Ave., Silver Spring MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only, one cause on each line /Medical Death Immediate Cause (Final disease a Hypertensive cardiovascular disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed tran and Physician/Medical the attending physician ed for use as the burial -X UNPENDED AMENDED 23a,27,permE, g899 1/28/10 TT Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Year past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown Completed has been s 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed 1 🗸 Yes certificate ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Hospital: 1 Inpatient Other<sub>4</sub> examiner? Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA this 1 Yes No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 28b. Time of Injury 1 X Natural 1 Yes 2 No Pending Director: I in by the f Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E January 8, 2010 - 1 MA 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31 Date filed Worth Day Year) 12 2010 32. Registrar's Signature State Registrar OCME DHMH 17 Rev 1/2001 **ORIGINAL** 

OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 0 00401 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 8, 2010 Year Carlos Manuel1 Rosado Vazquez 10:20 a.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1X M 2 . F Months Days Hours OCL Profesor 1950 Puerto Rico 584-28-8989 59 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director PR San Juan 1 Yes 2 No r items 23a or 2 ner must be no 10e. Street and Number 10f. Zip Code 00926 10g. Citizen of What Country? United States Parque Forestal, B-63 Poppy St. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. or than "natural", or iter the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2X Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1X Yes 2□No Specify: Puerto Rican White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) d 2 should be filed within 72 alth and Mental Hygiene.
127 is marked other than "I rraumatic event, the Med 5 College (1-4 or 5+) Elementary/Seconday (0-12) Director Human Resourses Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carlos Rosado Rivera Esther Vazquez 19a. Informant's Name/Relationship (Type, Print) Idalia Torres Correa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, (wife) 1 and 2 soft Health a item 27 i Parque Forestal, B-63 Poppy St., San Juan, PR 00926 Date 9, 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 Jan 2010 Page 1 <u>≒</u> 5 permit. Page Department of Important: If any injury or Chesapeake Crematory Beltsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Se vice Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed?

1 Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical Be B 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending iniury Accident
Suicide Investigation М 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 8, 2010 D69288 NOSE

Registrar

DHMH 17 Rev 7/2009

State

Uodit Negusse M.D., 1600 Forest Glen Rd., Silver Spring, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Roger J. Vogelsinger Physician/ January 8 2010 2010 10:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 🖾 M 2 🗆 F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min Nov. 6 Pay, Year 32 Director 210-26-0656 77 Pennsylvania Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Potomac 1 🗆 Yes 2 🎦 No 10f. Zip Code 10g. Citizen of What Country? Funeral 8516 Scarboro Court 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 ri les, Give Year or Dates, 1956–1958 If Yes, Give 1 ☐ Yes 2 🔀 No Specify. White 3 Divorced Completed Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Computer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter E. Vogelsinger Margaret McLain f and 2 should b f Health and Mei item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy G. Vogelsinger/Wife 8516 Scarboro Court, Potomac, Maryland Baltimore, 20b. Place of Disposition (Name of Montgomery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Januar 4 Donation 5 Other (Specify) Bethesda, Maryland 12, 2010 Crematorium. Inc. 21. Signature of Fundal Se ce Licensee 22 Name and Address of Facility Robert A. Pumphrey Funeral Home, 7557 Wisconsin Ave., Bethesda, MI Bethesda-<u>C</u>hevy M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Onset and Death Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pneumonia 5 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires Chronic Obstructive Pulmonary Disease Records, 1 ☐ Yes 2 ☐ No 3 🖾 Probably 4 ☐ Unknown peen 24a. Was an Were autopsy findings available prior to completion of cause of certificate has autopsy performed? Yes 2 ☑ No death? 2 🗌 No 1 Yes completed filled in by the funeral director, Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 A Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) o 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 X Natural 2 Accident
3 Suicide 1 Yes 2 No after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only on 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D0065720 January 9, 2010 mpleted cause of death (lem 23a) (Type, Prin e and address of person wh Rosemary Iwunze, 8600 🞢 d Georgetown Road, Bethesda, Maryland M.D. 20814 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Patricia Ann Vuncannon Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Deat Baltimore Washington Med 8. Date of Birth (Month, Day, Mar 4, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 219-26-2542 Director Maryland Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No MD Anne Arundel Glen Burnie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 7975 Crain Hgwy Unit 407 21061 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1  $\square$  Never Married 2  $\square$  Married δ 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white If Yes, Give Specify: 3 ₺ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) social worker social services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Lloyd Sr Edna Mae Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Brenda Galluzzo/daughter 205 Woodhill Drive #E Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗌 Burial 2 🗀 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☑ Donation 5 ☐ Other (Specify) Signatur Funeral Service License Ronald S. W 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 <u>Baltimore</u>, 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphock, or head failure. List only one cause on each line. Onset and Death Immediate Cause (Final LSQUER ulmonar Priysician/ hronic disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician a sthe burial-1 Physician/Medical P.O. Box 68760 attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 2 🗌 No s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably + ☐ Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 24 hours after death.

Funeral Director. After this certificate has leted filled in by the funeral director, page 2 s autonsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 27. Mann of Death 1 Natural 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29c. License number D 4 1 3 4 5 30. Name and address of person who completed cause of death (Iter 23a) (Type, Print) HOSpital Drive, Glen Burnie,

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

uncannon

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00404 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January Da 10, 2010 Marie Fink Whiting 5:38 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF 219-22-0978 April 29 1923 86 Maryland Director Usual Residence of Decedent "natural", or items 23a or 28a-f show sdical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Parkville 1 🗆 Yes 2 🖺 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8829 Wilson Avenue 21234 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🖾 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by Black White etc. 1 Never Married 2 Married 21215-0036 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify: white If Yes, Give 3 XWidowed 4 Divorced Year or Dates Health and Mental Hygiene. tem 27 is marked other than "natur wher traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NQT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) C&P Telephone Elementary/Seconday (0-12) College (1-4 or 5+) Clerical duties Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John A. Fink Ellen J. Moales 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Zoltowski-niece 1162 Pelham Wood Road-Baltimore, Maryland 21234 or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery Jan.14,2010 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans. Funeral Chapel and Cremation Services
8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on such line. Interval Between Onset and Death Immediate Cause (Final Physician/ caso disease or condition Medical resulting in death) (or an a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 of onths?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? Hospital or Attending Physician; The 124 hours after death. Funeral Director: After this certificate? perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) NOS PLO 27. Manner of Death 28a. Date of injury (Month, Day, Year) Medical Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 Accident М 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year)

State

30. Name and

31. Date filed (Month, Day, Year

Maryland

Box 68760

P.O.

Records,

**Division of Vital** 

6 K

address of person who completed cause of death (Item 23a) (Type, Print) ARURS

MI

State of Maryland / Department of Health and Mental Hygiene 00405 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Month Day 1/5/2010 Year **Physician** 9:00 A M Martha Virginia Wright /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 3200 Mail Road Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/25/1913 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1 □ M 2 🔀 F Yrs. Director 213-50-2768 96 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2 No Director Carroll MD Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 'natural", or items 23a Completed by Funeral 3200 Mail Road 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ∐Yes 2**XX**No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2XXNo Specify: 3XXWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Her Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be to Department of Health and Mental I important: If Item 27 Is marked oft any Injury or other trainment Be Carrie Harmen Lewis Barnes ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3151 Mail Road, Westminster, MD 21157 Hearl L. Wright/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 1/9/2010 4 ☐ Donation 5 ☐ Other (Specify) James Cemetery Dennings, MD 21. Signature of Funeral Service License Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Approximate Interval Between Opset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cerdro Vasculor theroscleni **Physician** 2 9YS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 HNo 2 No 1 🗌 Yes 1 Tyes 25. Was case referred to medica Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier ساح 2010 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21152 NO Honey 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

10-00072 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Arthur Whitaker State of Maryland / Department of Health and Mental Hygiene 2010 00406 1. For State Certificate of Death Registrar 2. Date of Death nt's Name (First, Middle,La 3. Time of Death Physician/ Month Day January 3, 2010 **Medical Examiner** 1940 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2012 Jefferson Street Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Days Months Hours Min Director 1 X M 2 F Usual Residence of Decedent 10a State I0c. Cify, Town or Location 10d. Inside City Limits 23a or 28a-f show notified at once. 1 Yes 2 No es 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Director 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country 2012 rson Funeral 11. Marital Status 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Noit; If item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner must be White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Yes Black 1 Yes 2 No specify: Widowed 4 Divorced If Yes, Give Year ۵ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 11-6 Be 19b. Mailing Address (Street and Number or Rural Route Number, Relationship (Type, Print) Knother Beaumont Avenue 20b. Place of Disposition (Name of cemetery, Date 2 Cremation 3 Baltime Removal from State 4 Donation 5 Other Specify. 21. Signature of Funeral Se ase, or complications that caused the death. Do not enter the node of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease a Narcotic (morphine) intoxication Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical X UNPENDED AMENDED signed by the attending physician be detached for use as the burial 23a, PII, 27, 28a-f, permE, g899 1/28/10 TI Division of Vital Records, P.O. Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Acquired immune deficiency syndrome Completed has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗹 Other: Scene DOA 1 🗸 Yes 2 No 28d. Describe how injury occurred 27. Manner of Death 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work' Certification: Natural 1 Yes 2 XNo filled in by the f Pending Fd 1/3/10 Fd 7:30 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be found at home or Town, State) 2012 Jefferson St. Baltimore, MD

the Hospital or Attending Physician:

Medical

one)

Donna M. Vincenti, MD 31. Date filed (Month, Day State Registrar

29b. Signature and title of certifier

Assistant Medical Examiner

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 4, 2010

30. Name and address of person who completed cause of death (Item 23a)

determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 | 0

			For State Registrar	State of Maryla		rtificate of L			Reg. No. 201	0 00407			
Physician/			1. Decedent's Name (First, Middle, Last)  Doris  Je				2. Date of Dea Month			3. Time of Death 1536 M			
Medical Examiner			4a. Facility Name (if not institution, give st		Week	4b. City, Town, or	Location of Dea	th	9 201 4c. County of D				
1	Baltimore Washington Medical Center				Glen B	ırnie			Anne Arundel				
	Director         217–22–5089         1 □ M 2 ☑ F         82         Yrs.         Months					If Under 1 Year Months Days	If Under 24 Hrs Hours Min			Birthplace (State or Foreign Country) MD			
	and show at	or	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation			10d. Inside City Limits				
	Maryl 28a-f otified	Director	MD Anne A	runde1	Glen	Burnie				1 ☐ Yes 2 🛣 No			
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral D	10e. Street and Number 507 Oakleigh Ave.			10f. Zip Code 210	061		10g. Citizen of What	Country?			
	death items		11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - A Black, W	merican Indian,			
Maryland 21215-0036	rs after ral", or Exami	ed by	1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced	1 ☐ Yes 2 🛛 No If Yes, Give Year or Dates.		1 ☐ Yes 2 🔀 No		,	Ci6:	white			
2-0	'2 hou "natu edical	plet	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual Occup kind of work done o	ation during most of wo	rking	16b. Kind of Busine	ess Industry			
7121	vithin 7 liene. rr than the M	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)		ONOT use retired) ome_make1	•		home own	ier			
pu	filed value of othe		17. Father's Name (First, Middle, Last)			OME MAKE		ıme (First, Middle, i	Maiden Surname)				
ryla	uld be d Ment marke natic	욘	Edward Paul	Bowman				Irene (unkn)					
Ma	12 sho lith and 27 is r		19a. Informant's Name/Relationship (Type Mr Bruce Weeks/son			,			r, City or Town, State, MD 21061	Zip Code)			
ore,	of Hee of Hee fitem		20a. Method of Disposition  1  Burial 2  Cremation 3  F	206	. Place of Dispo		1	Date	20c. Location - City	or Town, State			
Baltimore,	t. Page tment tant: I		4 Denation 5 Other (Specify)	Me	etro Cre	matory	1/1	2/2010	Elkridge				
Bal	Depar Impor any ir		21. Signatur S Vis Contract	M013	64 42	2. Name and Addres 21 Crain	ss of Facility K: Hwy SE G	irkley-Ru len Burn	iddick Fun ie MD 210	eral Home PA			
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one	cations that caused the decause on each line.		,			_	Approximate Interval Between			
	mysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Chronic	_ 0	bstruc	thre 1	wwg	DISKNSR	Onset and Death			
مبيد	Examiner		Due to (or as a consequence of):										
	sit a	Examiner	Sequentially list conditions, it any leading to immediate cause. Enter Underlying	Due to for as a conse	еднегов сту								
	xecute	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a conse	equence of):								
1200	icate be executed g physician and is the burial-transit	dical		l,									
687	.≚ n.≌	/Me	IF FEMALE:	Bc. If yes, outcome of preg	nancy		<del></del>						
Box	eath ce attend	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 Live Birth 2 F 4 Pregnant at time	etal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	delivery Day Year			
P.O. E	t the d by the	Phys	g Unknowh	9 Unknown			. 5						
s, P.	requires that the death certific been signed by the attending p should be detached for use as	Completed by Physician/Medical	Part II. Other significant conditions con	W/W/S	resulting in the u	ingeriyin <b>g</b> cause giv	en in Part I.	23e. Did to		e to the cause of death?  Probably 4 🗆 Unknown			
ord		plete						24a. Was a		24b. Were autopsy findings available			
The lave the law and the law a					autop perfor 1 \sum Yes	autopsy prior to completion of cause of death?  1  Yes 2 No 1 Yes 2 No							
ta	cian: certific ector,	Be	25. Was case referred to medical examiner?	ospital:			ace of Death (Che						
ξ	Physic r this caral dir	<u>اء:</u> کو	1 ☐ Yes 2 MNo	1 Inpatient 2 28a. Date of injury	ER/Outpatier 28b. Time of		4 L Nursing	T	Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred				
ouo	anding sath. rr: Afte	ficate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work		Zod. Describe in	a. Describe now injury occurred				
building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check 2   Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3   Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								ne cause(s) and manner stated.					
r)	To the within 2 To the comple		29b. Signature and title of certifier			29c. License	number		29d. Date signed (Mo				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) was to bush million milli								V(V					
			30. Name and address of person who con	mpleted_cause of death (It		Cukin ?				uhi			
	Stat	e	31. Date filed (Month Day, Year) 10	32. Registrar's St	7	7			J				

DHMH 17 Rev 7/2009

Please Type or Print in Black/Indelible Ink. Ensure All Copies Are Legible. amend #20 b PET FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 | Pen FH G899 1 - For State Registrar 00408 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Month **Physician** 12:01A M James Edward Wilson Sr. 01 80 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. 5013 Truesdale Avenue 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 XM 2 ☐ F 238-44-7557 78 Director 12-21-1931 N. Carolina Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c City, Town or Location 28a-f show traumatic event, the Medical Examinar must be notified at Director 1√2Yes 2 No N/AMD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 21206 5013 Truesdale Avenue U.S.A. Funeral or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify 2 Specify 3 ☐ Widowed 4 ☐ Divorced 'natural", Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 th and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade District Mandger URS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eddie Mary ပ္ T. Wilson W. Kearney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once. Angela Reese(Grandchild) 1205 W. Lexington St., Baltimore, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place Joseph Brown F/And Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1/1472010 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/12/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home Mulamo 2140 N. Fulton Ave., Baltimore, MD 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Prostate **Physician** Metastatic 3 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 DISEASE ARTERY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes No page certificate 1 ☐ Yes 2 ☐ No 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 ☐ Matural 2 ☐ Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 40048 01-08-2010

State Registrar

Baltimore, Maryland 21215-0036

P.0.

Division of Vital Records,

DHMH 17 Rev 1/2001

N 1 2 2010 Seven S. Jacks

Begistrar's Signature

7505 OSLER DR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID BOERSMA

31. Date filed (Month, Day, Year)

**ORIGINAL** 

NO2WO I

21204

mD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month 3:36 PM 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Adventist Washinaton Hospita Koma la rince Georges Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Foreign **Funeral** 223-56-6796 1 M 2 KF Min **Director** September 30,194 Usual Residence of Decedent 28a-f shov 10a. State filed within 72 hours after death with the Maryland than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Washing 1 X Yes 2 No D 10f. Zip Cođe 10e. Street and Number 10g. Citizen of What Country? Funeral Street 000 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, <u>Ş</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) p John Health Care Nurse other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carberr Marie Davis awrence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgeware Way Wake Forest, North Carolina 27587 Brother H. Carberry awrence 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 13/2010 Fairfax Memorial 4 Donation 5 Other (Specify) Fairfax, Virginia Park 21. Signature of Funeral Service Licenses Funeral obest S. Shirlington Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, returns to immediate cause. Enter Underlying Examiner burial-transit certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last physician Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 1 Yes 2 the Unknown signed by the Other significant conditions contributing to 23e. Did tobacco use contribute to the cause of death? þ 2/ No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes page 2 should this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an yes 2 No 1 Yes Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2/1 No Hospital Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28c. Injury at work? 28b. Time of Certificate: 1 Natural 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After completed filled in by the funer (Month, Day, Year) 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 201

State Registrar Irvina St

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

106

Registrar
DHMH 17 Rev 1/2001

OCME 2006

State

29b. Signature and title of certifie

Melissa Brassell, MD

31. Date filed (Month, Day, Year) JAN 12 2010

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

ORIGINAL

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 7, 2010

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** SUMNEY 10.55 A M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** acroll arroll HOSPITAL westminste If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 15√2 M 2□ F 011-12-1553 98 July 1 1911 MA Director Usual Residence of Decedent with the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show or items 23a or 28a-f show 1 ☐ Yes 2 X No Directo MD Baltimore Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21042-5120 9312 Meadow Hill Road USA by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1ĂÎYes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 0 Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: r than "natural", o 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene. 27 Is marked other than ' r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Social Security Admin. Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar H. Whittier Eva S. MacNeil ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 46 Norwood Heights Gloucester, MA 01930 Health a Jaye A. Whittier item 27 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State t jo Department of Important: If it any injury or conce. 1-16-2010 Woodlawn Cemetery Everett, MA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Ambrose Funeral Home, Inc. 23a. Part 1. Enter the disluse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arbutus, MD 21227 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Year 5 Other (specify) been signed by the a should be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 sl performe 2  $\square$ No 1 ☐Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation nours after death.

neral Director: After in by the further in the 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 2010

Registrar DHMH 17 Rev 1/2001

State

31. Date

filed (Month, Day,

JAN 1 2 2010

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

32. Registrar's Signature

oney

295

2005994

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 2 per dvr., g899, 01/12/10dhb

Certificate of Death

Reg. No. 2 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 01/07/2010 3. Time of Death Physician Janie Mae Wilson 7:40 a Jan 7, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Baltimore 1202 Eutaw Place If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Hours Months Days Min. 1 □ M 2 □ F Director 87 224-10-0613 May 31, 1921 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f shov ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, It with all Evan it with usine and injury or other traumatic event, It with all events in the interest of the second or its secon 1x Yes 2 No Director Maryland N/A **Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1202 Eutaw Place U.S.A. 21217 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 → Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 ☐ No Specify Specify. 3 Widowed 4 Divorced Black Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, if a Mones. Church Minister 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William H. Wilson Sallie L. Wilson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4306 F. Street, S.E. Washington, D.C. 20019 Janet D. Clark 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 01/13/10 Danville, Virginia Forest Hill Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Estep Brothers Funeral Service, P. A.

23a. Part1. Enter the fdisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smooth, or heart sature. List only one cause on each fine. Immediate Cause (Final disease or condition resulting in death) stroke **Physician** YR /Medical Due to (or as a consequence of): Examiner per tension ears Sequentially list conditions, if any, local cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of) and Due to (or as a consequence of): burialattending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the 9 Unknown þ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy 2 No 1 □Yes 2 No 1 ☐ Yes Be 26. Place of Death (Check only one)

To the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, After this certificate funeral eral Director: /

Certification: To

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

hours after within 24 hours a

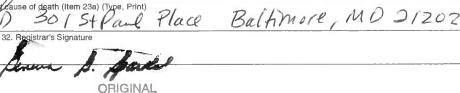
> State Registrar

Medical

31. Date filed (Month, Day, Year)

OMahony

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Physician/ Medical Examiner **Funeral** Director 28a-f shov the Medical Examiner must be notified at Director and Mental Hygiene. is marked other than "natural", or items 23a Funeral ģ Baltimore, Maryland 21215-0036 Completed Patient Known as permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be Physician/ Medical Examiner Examine burial-tran physician Physician/Medical Box 68760 the attending p

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Richard Lee Wilds, Sr. 12:38 AM 2010 muary 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death of Baltimere Hospital Baltimere N/A Sinai If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Days 1 X M 2 - F So. Carolina 1941 247-74-3239 68 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No N/A **Baltimore** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3908 Reisterstown Road 21215 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. 1 Never Married 2 A Married Yes 2 No If Yes, Give Year or Dates. 1 Yes 2 X No Specify Specify Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **BWI** Field Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mattie Wilds Charlie Wilds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3908 Reisterstown Road Baltimore', Maryland 21215 Penny Wilds 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn Park, Md. 01/15/10 Cedar Hill Cemetery & Mausdleum Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 213 23a. Part 1, Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death

3 days Immediate Cause (Final Sepsis disease or condition resulting in death) Due to (or as a consequence of): poten Sian Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events as a consequence of Due to (or as a consequence of): resulting in death) Last that the death certificate be IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 Fetal death in the past 12 months? detached for Day Month Year Yes 2 🗆 No 9 Unknown Division of Vital Records, P.O. conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacço use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 ie Nopen... in 24 hours affer death. the Funeral Director. After this certificate "enad in by the funeral director, pa 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ture and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2010 who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimera State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Month NCENT Kenneth Younger JANUARY 9. 2010 8:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford <u>Victorian Estates Assisted Living</u> Bel Air If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Maryland Director Auq. 15, 1917 220-20-7191 Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Harford Forest Hill Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21050 107 Sunshine Court 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 No Specify 2 Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Industrial Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alvena (unk) Rezac Howard I. Younger ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1233 Echo Ct., Bel Air, MD 21015 Vincent K. Younger II , Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Bel Air Memorial Gdn. 1-14-10 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** eno stock DEMPTIN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Ent. In the final Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. an/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy P.0. ed by the detached signed to be deta page

Division of Vital Records,

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To the Funeral C

lysic.	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Month Day real							
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Comple				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  10 1 □ Yes 2 □ No				
מ	25. Was case referred to medical examiner?		th (Check only one)						
2	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	□ DOA Other: 4 □ Nursing H	ome 5 Residence	e 5 ☐ Residence 6 ℃ Other (Specify)				
ation.	27. Manner of Death  Natural 5 Pending 2 Accident investigation		28c. Injury at Work?	28d. Describe how inj	d. Describe how injury occurred				
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ancai			(s) and manner as stated. nd place, and due to the cause(s)						
Ž	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Day, Year)				
	Drang 34		D3 7295	JE	JAN VALY 11,7010				
	30. Name and address of person who c								
	DAVID 5 DUNY GIEW. Mo. Phy / Bel Air, MD 21014								
	31. Date filed (Manth, Day Year) 32. Registrar's Snature								

State Registrar

			<b>pe or Print i</b> State of Maryl	and / Depa		ealth and M	lental Hyg	-	00416		
	Physician /Medical  1. Decedent's Name (First, Middle, Last)  MARTIN			YORK SR.			2. Date of Death Month Day Year JAN. 09 2010 4:50 A. M				
Examin		4a. Facility Name (If not institution, give str FAYETTE HEALTH AND	eet and number)		4b. City, Town, or I	ORE	01111	4c. County of Dea			
Funeral Director		5. Social Security Number  248-28-6462  Usual Residence of Decedent	7. Age (In 90	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, <b>07–08–1</b>	Year) Co	thplace (State or Foreign ountry) SC		
show	o.	10a. State 10b. County		. City, Town or Lo					10d. Inside City Limits 1 → Yes 2 No		
h the M	Director	MD BALTIMOR 10e. Street and Number	E	CATON	10f. Zip Code		1	0g. Citizen of What Co	A		
s 23a c	Funeral [	1022 LAKEMONT RD	W D l E			228		BALTIMORE			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Nadical Evanine must be notified at once.	by	11. Marital Status 12 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	. Was Decedent Ever if Armed Forces?  1 ★es 2 No If Yes, Give Year or Dates: WW		Was Decedent of His fYes, specify Cubar I □Yes 2 🛣 lo		Rican, etc.)	14. Race - Ame Black, Whit Specify: <b>BLA</b>	e, etc.		
in 72 h in matu	Completed	15. Decedent's Educat (Specify only highest grade of	completed)	(Give	dent's Usual Occupa kind of work done du DO NOT use retired)	uring most of worki	ing	16b. Kind of Business	/Industry		
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12 should be filed within h and Mental Hygiene. 7 is marked other than traumatic event, the Mental Hygiene.	To Be (	17. Father's Name (First, Middle, Last)  MARTIN J. YORK				18. Mother's Name		Maiden Surname)			
and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (Type DONNA GILLIAM/ DAU	,					; City or Town, State, E, MD 2122			
Pages 1 and 2 nent of Health a int: If item 27 inry or other tra		20a. Method of Disposition  1 ▼Burial 2 □ □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)	noval from State	b. Place of Dispo cemetery, cren	natory`or other place	) :		20c. Location - City or			
permit. Departimonts any Inju		21. Signature of Funeral Service Licensee	Morta	n 22	. Name and Address			MORTON & S MORE, MD 2	ONS F.H., INC 1217		
pricia pe	cal Examiner	23a. Part. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	renal asequence of): the hasequence of):	fact	failme			Approximate Interval Between Onset and Death  3 m MZ  3 m MZ		
The law requires that the death certificate are has been signed by the attending phys bage 2 should be detached for use as the l	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   5   Other						23d. Date of delivery  Month Day Year			
w requires that sheen signed should be det	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown									
n: The law re icate has be r, page 2 shc	Completed	24a. Was an autopsy performed 1 □ Yes 2 Z							prior to completion of cause of ed? death?		
Physician: T this certificat al director, pa	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hos	spital:	2 ER/Outpatier	Otho	26. Place of Death		ence 6 □Other (Spe	ecify)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, I	ation: T	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Yea	28b. Time of	28c. Injury Work	at		ow injury occurred	outy		
ital or Att ins after de ral Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	At home, farm, stroecify)			City or Town	n (Street and Number or Rural Route Number, Town, State)				
e Hosp 24 hou e Funei letely fill	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Physic 2 ☐ Medical Examine	cian: To the best of my r: On the basis of exa and manner stated.	knowledge, deatl mination and/or in	n occurred at the tim vestigation, in my op	e, date and place, pinion, death occur	and due to the d red at the time, d	cause(s) and manner a late and place, and du	as stated. e to the cause(s)		
To th withir To th comp	Me	29b. Signature and title of certifier	Kiring		29c. License	7/865	2	9d. Date signed (Mon	th, Day, Year)		
grlv		30. Name and address of person who com	PZI /	(Item 23a) (Type,	Print) .n Heet	Ba	etimore	ma	21W/		
Sta Registr		31. Date filed (Month, Day, Year)  JAN 1 2 2010	32. Registrar's S	Signature	,				,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 00417 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1110 M ANNO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 N. Meadow Drive Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Yea July 24, If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Mary land 1 M 2 F Months Days Hours 59 Director 577-70-4803 Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b County 10d. Inside City Limits 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No MD Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 1 N. Meadow Drive 21060 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Was Deceden Lvo. Armed Forces? 1 🔲 Yes 2 🔯 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2X No Specify: Specify: white 3 Widowed 4 X Divorced Completed al Hygiene.
I other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the barmaid tavern Be Page 1 and 2 should be filed iment of Health and Mental Hy cant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Emma Lee Wilson Jacob Cenior Sponaugle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 N. Meadow Drive Glen Burnie, MD 21061 Larry Riggs/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 - Other (Specify) 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signatur of Line | Service Licen Mirector Baltimore, ΜĎ 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. i RRHOSis Onset and Death Immediate Cause (Final disease or condition IVER Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed | 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No After this certification funeral director, I 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital: Other: 2 No 1 Tyes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural work? iniury 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Print) DETENCE HIGHWAY ANNAPOLIMOLING Name and address of person MICHAR. 445

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

10-00131 David Burton Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 0413

	1- For State Certificate of Death Reg. No.												
Physician/ 1. Decedent's Name (First, Middle,Last)  Medical Examiner David Burton								Date of Dea Month January 5	Day Ye	ar	3. Time of Death 1005 hrs		
	4a. Facility Name (if n					4	b. City, Town, or I Baltimore	Location o	of Death	4c. County of D		of Death	
Funeral Director	5. Social Security Num 212-40-3		7. Age (In yrs. last birthd			hday) Yrs.	If Under 1 Year Months Days			8. Date of Birth (MM/DD/YYYY) 9. t 6-16-1944			
' any		Isual Residence of Decedent											10d. Inside City Limits
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h the Maryland 3a or 28a-f sh otified at once			Avenu	е			10f. Zip Code 212	18			0g. Citizen of W US		ury?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	3 VVIdowed	4 X Divorced	or Dates:	orces? 2 N	0	If Ye	Decedent of Hisp s, specify Cuban, Yes 2 X No	Mexican, specify:	Puerto R	ican, etc.)	Whit	e, etc. B	can Indian, Black,
5-0036 ed within 72 hours tygiene. other than "natur the Medical Exam Completed 1	15. Decedent's Educ	dary (0-12)	College (1		- (	during mo	s Usual Occupationst of working life.				16b. Kind of B		
21215-0036 build be filed within 7 Mental Hygiene. marked other than c event, the Medica		rst, Middle, Last)	Sr			D1.			,	irst, Middle, I	Maiden Surname		
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tinjury or other traumatic event, the Meg To Be Com		e/Relationship (Ty	Type, Print ) 19b. M			Mailing	Mailing Address (Street and Number or R 331 Gorsuch Avenu			Rural Route Number, City or Town			Zip Code) 218
Ore, N ges I and 2 of Health If item 2 ther trau	20a. Method of Dispos	sition	3 Removal from State 20b. Place of cremator			ory or othe	Disposition (Name of cemetery, y or other place)			Date 20c. Location - C			
Baltimore, bernit. Pages I ar Department of Hee important: If ite njury or other fr	4 Donation 5 21. Signature of Funer	Other Specify: ral Service Licens	see		Garr:		Forest me and Address					s M '/H	ills, MD
Balt Balt Departing Important Import		Signature of Funeral Service Licensee  22. Name and Address of Facility  March East F/  1101 E. North Avenue Balt  Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart							to,	Approximate Interval			
/Wedical Examiner	failure, List only Immediate Cause (Fin or condition resulting)	istonly one cause on each line.  Betwause (Final disease a Atherosclerotic cardiovascular disease							Between Onset and Death				
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if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):													
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Division of Vital Records, P.O. Box 68760,  Boylial or Attending Physician: The law requires that the death certificate be executed the hours after death.  Funeral Director: After this certificate has been signed by the attending physician and lety filled in by the funeral director, page 2 should be detached for use as the burial—trans all Certification: To Be Completed by Physician/Medical E.									ey .	Month Day Year			
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Records, F The law requires ficate has been sign , page 2 should be Completed	Steatosis of the liver, prostate cancer								24a. Was an autopsy prior to completion of cause			topsy findings available	
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Vital Recysician: The libit certificate by director, page	25. Was case referred examiner?	H	ospital: 1 Ir	npatient 2	✓ ER/Ou	ıtpatient	7.	of Death (			Residence 6	Other	<del></del>
nn of Vi nding Physi th. : After this e funeral dir ion: To	1 🗸 Yes 2 27. Manner of Death	No Pending	28a Date			ime of Inj	ury 28c. Injury	at Work?	- 1	3d. Describe I	now injury occur	ed	
Division of Vital Records, P.O. Division of Vital Records, P.O. ospital or Attending Physician: The law requires that the hours after death.  Ineral Director: After this certificate has been signed by y filled in by the funeral director, page 2 should be detach.  Certification: To Be Completed by P	2 Accident 3 Suicide 6	Investigatio Could not b determined	e 28e. Place	e of Injury - A	t home, fa	rm, street,	havened beginned				nd Number or Rural Route Number, City		
NK N 플로플 플 이 이미의 기계 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur													
PECU PEPE	29b. Signature and title		and manner st	ateu.			29c. License O.C.M				29d. Date sign		ith, Day,Year)
Ø	30. Name and address Donna M. Vino					111	Penn Street,	Baltimo	re, MD	21201			
State Registra		Pay Year)	32. Re	gistar's Sign	lature A.K.	, '				· · · · · · · · · · · · · · · · · · ·			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 6:15 P M **Physician** 7, 2010 January Robert Samuel Burr /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Catonsville Glynn Taff Assisted Living Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X** M 2 □ F 95 Nov.19, 1914 Maryland 217-09-9126 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Exp. draw must be redified at 1 □Yes 2K No Director Catonsville MD Baltimore 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with USA 21228 5741 Edmondson Avenue Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Mayes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 WHite 1∐Yes 2√∑No Specify Be Completed by 3 Midowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Trucking 7 is marked other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be f Health and Mental Mary E. Robertson Ezra S. Burr ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2004 Norhurst Way South; Catonsville, MD 21228 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. Daughter Margaret Greene 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, MD Glen Haven Mem. Park 1/11/2010 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 416# 21. Signature of Funer MOIS 37 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. DISEASE Immediate Cause (Final DEONALY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner MABETES that the death certificate be execut attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown ģ σ. signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 □ No 1 ☐ Yes 2 No 1 TYes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) GLYPNTAFF Other: 4 Nursing Home 5 Residence Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ ō this After this funeral d 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 24 hours after death Funeral Director: the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2.

Registrar

29b. Signature and title of certifier

SAMU

Frederick Road Ste 162

MEDICAL POCTOR [1006350]

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year 10:10PM Cecilia Velma Bauhaus JAN 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES BALTT' MORI If Under 1 Year If Under 24 H HOSPT Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, ) 7/7/1941 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 🕱 F Hours Maryland **Director** 219-38-4402 68 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nnt: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f shoredical Examinar must be notified at Director 1x Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2001 Ashton Street 21223 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 <u>ک</u> 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 X Widowed 4 Divorced er than "natur , the Wedical I 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 10 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William မှ Howard Bowers Regina Beatrice Townsley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Paschall / Daughter 5414 Union Mission Ln., Crozet, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 1/12/2010 Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature Funeral Service Licensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNE UMONIA 2 DAYS ASPIRATION disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be execute signed by the attending physician and be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1  $\square$  Live birth 2  $\square$  Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal dea 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 2 ERE BROVASCULAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s 24a. Was an autopsy perform 2 **N**0 Vital 2 DE No 1 □Yes 1 ☐ Yes Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 patient 2 ☐ ER/Outpatient 3 ☐ DOA of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JAN 5 2010 P-24065 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATON AVE BALTIMORE FARIA AMJAO 900 MD-21229 32. Registrar's Signatu State

DHMH 17 Rev 1/2001

Registrar

BAUHAU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #1, per MD g900 2/2/10 TT
State of Maryland / Department of Health and Mental Hygiene 2 | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) John Albert Brown 2. Date of Death 3. Time of Death Day **Physician** 02:65 AM 2010 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALT MORE Community Living If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 09 17 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Year) X□M 2□F Yrs. Director 220-12-9506 85 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f shov ner must be notified at 1XYes 2 □ No Director MD Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 3716 Hillsdale U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23ary or other traumatic event, the Nedical Examiner must Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐Yes X☐No Specify: Specify: Black 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Superisor Bank 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary E. Lucas ပ John A. Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Brown-Daughter 606 Leafydale Terr., Pikesville, Md 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department of Important; If any injury or once. Garrison Forest Vet 1/14/10 Owings Mils, Md 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 119 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) s been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has rail director, page 2 s autopsy perform 2 No 1 □ Yes the Hospital or Attending Physiclan: Inin 24 hours after death.
the Funeral Director: After this certifica mpletely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of cegtifie 29d. Date signed (Month, Day, Year) 2010

State Registrar

the Maryland

21215-0036

Baltimore, Maryland

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Andrew

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900

21218

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

JAN 1 3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00424 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Пау Year **Physician** Charles Winfield Baker 2:25  $A^M$ 2010 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford <u> Upper Chesapeake Medical Center</u> Bel Air Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) ocial Security Number Funeral 1 **X**M 2□ F Days Hours 88 220-18-5518 2/9/1921 Director Maryland Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location ed other than "natural", or items 23a or 28a-f show event, the Madeal Examinar must be ricified at 1XYes 2□No Director Harford Aberdeen Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21001 215 Hemlock Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 DX es 2 1 942-53
If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify White 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 XNo Specify ò 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Education School Teacher permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If Item 27 Is marked other the any injury or other trauments. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel Ridgley Pendleton Tevis Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 215 Hemlock Lane, Aberdeen, MD 21001 Barbara Baker (wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Aberdeen, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1/18/2010 Baker Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Maryland 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
333 S. Parke St, Aberdeen, MD 21001 21. Signature of Funeral Service Licensee Snall rantas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Staph Aureus Bacteremia with Sepsis Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 🗆 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 □Yes 2 No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Mapner of Death 28c. Injury at 28d. Describe how injury occurred Hospital or Attending P 24 hours after death. Funeral Director: After t 1 Natural 2 Accident 5 ☐ Pending investigation 1 □Yes 2 □ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (*Month*, Day, Year) 29d. Date signed (*Month*, Day, Year) 2010 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. McPha. 1 Rd. BelAir, Md. 21014 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar IAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 2010 January 10:00A Carter Marv E. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Pasadena Anne Arundel 8424 Maryland Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days 1 □ M 2 🖾 F Hours Dec. 02 1945 214-46-0547 64Yrs **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8424 Maryland Road 21122 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White 3 - Widowed 4 - Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72. the and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Salesperson Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once. Albert Frederick Bussey Fanny V. Redin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald P. Carter (spouse) 8424 Maryland Road, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. Date 13 1 🗆 Burial 2 🖾 Cremation 3 🗔 Removal from State Metro Crematory Inc. 4 ☐ Denation 5 ☐ Other (Specify) 2010 Baltimore, Maryland Stallings Funeral Home, P.A. 21. Signati 22. Name and Address of Facility 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the c shock, or heart fai that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. or comply re. List only on Immediate Cause (Final Physician/ CUMD Y disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or linjury Due to or as a consquence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 2 40 1 Tes ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation М 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) within 24 hours a To the Funeral D 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1400 and

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death Physician/ OURTMAN Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Annapolis 920 Berwick Drive Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days ¶ 2 □ F Months 55 **Director** 551-63-4338 18,1954 England Usual Residence of Decedent or 28a-f show se notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County with the Maryland Director Annapolis 1 XYes 2 No Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be Funeral England 21403 920 Berwick Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry st grade completed) (Give kind of work done of life. DO NOT use retired) during most of working College (1-4 or 5+) Elementary/Seconday (0-12) Carpentry Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Goldschmidt Eva Albert Edward Courtman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 920 Berwick Drive, Annapolis, MD 21403 Maria van Beuren / Fiancee Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🙀 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) 1/12/2010 Woodbine, MD Journey Crem. 21. Signature of Funeral Service Licen ee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services DO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onse and Death Immediate Cause (Final disease or condition 40DER Priysiciani Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last signed by the attending physician and be detached for use as the burlal-tran Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? Yes 2 No To the incorrect within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2/ No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury Natural 5 Pending М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif cha

Registrar

State

31. Date filed (Month, Day, Year)

JAN 13

leted cause of death (Item 23a)

Registrar's Sign

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month Margaret Mary Collett 3:30 January 11,2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Middle River Baltimore Ivy Hall Geriatric Center If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Months Days 1 □ M 2 🔽 F 85 216 14 8569 May 8, Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1 Brett Court, Apartment 102 21221 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ▼ No Specify: 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Secretary 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Bauer Margaret Shinnick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2528 Hillcrest Avenue, Baltimore, Maryland 21234 Mary Kuerberth (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory Inc 1/12/2010 Baltimore, Maryland 21. Sanature of Funeral Service Licensee Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 Parth Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sels consequence of: Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2No 3 Probably 4 Unknown 1 ☐ Yes

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

'natural'

the Medical

within 72 hours after

e filed within all Hygiene.

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Pages 1

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permit. Pages 1 and Department of Health Important: If item 27 any Injury or other to

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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physician a s the burialattending pl ed by the a been si has

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Division or Vital Records,

Physician:

or Attending

the Hospital

Examiner Physician/Medical 2 Completed certificate Be 0 After this Certification: death. within 24 hours after death

To the Funeral Director:
completely filled in by the

		24a. Was an autopsy performed? 1□ Yes 2™No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No								
25. Was case referred to medical examiner?	26. Place of Death (Check only one)									
1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home	e 5 ☐ Residence 6 ☐ Other (Specify)								
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work?  I M¹ 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier 1	ysician: To the best of my knowledge, death occurred at the time, date and place, and niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause(s) and manner as stated. I at the time, date and place, and due to the cause(s)								

29b. Signature and title of certifier

29c. License number D61907

29d. Date signed (Month, Day, Year) 2010

124 Mace Avenue, Baetimore MD 21221

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) Day Year **Physician** INIA 2010 /Medical street and number **Examiner** Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In vrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 XF China 214 64 0960 83 Director 05/16/1926 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Exemines must be required an once. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 AYes 2 No Director N/A Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21225 U.S.A. 4146 Doris Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No ģ Specify: Asian 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hung Sum Hui Gem Gee Lim ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Raymond Chin / Son 16004 Howard Landing Drive Gathersburg, MD. 20878 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/18/2010 | Baltimore, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signalura Fun ral Service King 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardiovascular Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE detached for use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) ☐Yes 2 No the 9 Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 🗆 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has autopsy certificate 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 o Certification: To 1 Inpatient 2 R/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier EcertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 0036819

State Registrar

401 old Court Roa strar's Signature 31. Date filed (Month, Day, Year)

Me

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Michael Draughn 10:55 2010 January 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonard town
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. St. Mary's 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 □ F Director 66 579-56-5642 11/29/1943 Washington, D.C. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State if of Health and Mental Hygiene.
If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evaminar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No **Funeral Director** St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37335 E. Spicer Drive 20659 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Completed by 1 ☐Yes 2 🛣 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Dept. of Energy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be fill Health and Mental H Be Fathon 2 Draughn Lucille Grant Ouinn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie Draughn / Wife 37335 E. Spicer Dr., Mechanicsville, MD 20659 Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department c Important: If any Injury or 4☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 1/12/2010 | Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service License 7522 Connelley Dr., Ste. P. Hanover, MD 21076 23a. Part1. Enter the disease, o conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RESPIRATORY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): PNEUMONIA **Examiner** HOURS ASPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). GASTROPANESSS pital or Attending Physician: The law requires that the death certificate be executed ours after death. eral Director: After this certificate has been signed by the attending physician and filled in by the funerated director, page 2 should be detached for use as the burial-transit DAYS Due to (or as a consequence of): IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MYELOWA MULTIPLE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CORONARY ANTERY MIGHIE 24b. Were autopsy findings available prior to completion of cause of death? autopsy END STAGE performed' 1 ☐ Yes 2 🗷 No 1 □Yes 2 □No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1.☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

670 P.0. To the Hospital within 24 hours a To the Funeral C

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

FAJGINDER

31. Date filed (Month, Day, Year) 32. Registrar's Signature

G'LL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MA

29d. Date signed (Month, Day, Year)

STMARY; MOSPITAL LEONARY TOWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month rian 4:32 A M anuary 2010 Medical 4a. Facility Name (if not institution, give stre City, Town, or Location of Death 4c. County of Death **Examiner** altimore N/A 60 If Under 1 Year | If Under 24 Hrs. Age (In vrs. last birthday Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 □ F Months Days Hours Min. 49 Mary land Director 219 80 7332 Usual Residence of Decedent 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Anne Arundel Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 U.S.A 436 Seward Avenue 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 🗆 Widowed 4 🗆 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Production Manager Hohmann Barnard vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul H. Daley Joan A. DeMartin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Cheek / 7527 Jacqwill Road Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Sacred Heart of Jesus 01/14/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner S uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last burial-1 attending physician for use as the burial Medical Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy Physician/ 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Pregnant at time of death the detached 9 Unknown Division of Vital Records, P.O. signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 4 Unknown 2 No 3 Probably Completed 1 Yes peen Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 : autopsy performed this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Funeral Director, After completed filled in by the funer (Month, Day, Year) Natural 5 Pending work death. Accident 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The discourse of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check the only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar South Hanover Street Baltimore, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:27 A M DEBORAH N DENARO SANUARY 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death JOHNS HORKENS BANKEW MEDICALCENTER BALTIMARE Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last hirthday) 8 Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours 12-17-1960 1 🗆 M 2 🛛 F Maryland Director 49 218-78-1380 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No N/A MD Baltimore 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 6714 Duluth Avenue Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ٥ þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene, N/A Home Maker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental item 27 is marked Frank Walter Ciotola Patricia Anne Webb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6714 Duluth Avenue Baltimore, MD 21222 David M. Denaro-Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Bayview Crematory 1-13-2010 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. and Death Immediate Cause (Final Physician/ 6 HOURS GI BLEED disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** ZYEARS ALCOHOLIC CIRRHOSIS Sequentially list conditions, if any, leading to immediate cause Fater Uncerning Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Dav Pregnant at time of death 1 Yes 2 Unknown 2 No Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No certificate har irector, page 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 12 No Hospital Other: ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at (Month, Day, Year) 1 Natural 5 Pending s after death.

I Director: Af
d in by the fur ☐ Accident M 1 Yes 2 No Investigation Suicide 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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JANUART 12, 2010

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2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

P.O. Box 68760 Records, Hospital or Attending Physician: The law **Division of Vital** 24 hours within 24 hours To the Fune completed fi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE · C.M LAROCHELLE 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009 **ORIGINAL** 

29b. Signature and the of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year 0814 MARGARET DOUGHTY Kin Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Sina the spital of Bultime Baltimore N/A If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F (Month, Day, Year 5-10-193 Months Days Hours Min. Director MARYLAND 218-26-6575 78 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD. BALTIMORE RANDALLSTOWN DO UG (474) 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3927 LAUSANNE RD. 21133 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. 0 Completed by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK "natural", 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour popartment of Health and Mental Hyglene. Important: If item 27 is marked other than "natuu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) -12--0-CLERK TRANSPORTATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ DELMAR GROSS ETHEL PARKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRENE MONTAQUE (DAUGHTER) 3927 LAUSANNE RD. RANDALLSTOWN, MARYLAND 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ ¢remation 3 ☐ Removal from State 4 ☐ Donation 5/☐ Other (Specify) ZION CEMETERY 1-11-2010 BALTIMORE, MARYLAND 21. Signature of Funeral Service Lice secTONATHAN HIBNER2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1/Enter the disease, or complications that caused shock, of heart failure. List only one cause on each line. Immediate Gause (Final disease or ondition er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Priysician/ STAGE 4 ENDOMETHIA CANCER Medical resulting in death) Due to (or as a consequence of) **Examiner** 1 year metais tanis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) bunial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) 9 Unknown 9 Unknown P.O. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, The law requires 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical or Attending Physician: Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 🗷 Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

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31. Date filed (Month, Day, Year)

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OF Brilhmore 2401

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6,2010

W. Belvedy

2/215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav David Lee Ellis, Sr ам 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center

5. Social Security Number 6. Sex Towson Balto 7. Age (In yrs. last birthday) Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 6-12-1949 1 X M 2 □ F Director 223-70-4965 Usual Residence of Decedent 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1624 E. 25th Street 21213 USA "natural", or items should be filed within 72 hours after death vand Mental Hygiene.
is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 Yes 2X No Specify: Black 3 ₩Widowed 4 Divorced Completed Year or Dates. traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12th grade Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Page Cora Ellis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. <u> Ali Ellis-Son</u> Taos Circle Balto, MD 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Oaklawn Cemetery 1-8-2010 Balto, MD 22. Name and Address of Facility March East F/H 21. Signature of Fun ral Service Licensee Snap Miller 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 2007 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Por in the past 12 months? Pregnant at time of death Month 2 No 1 Yes 2 L 9 Unknown be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Conflicting Nurse Practice To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2 D64395 JANUARY 1, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIENE DOBERMAN, MD 6701 N. CHAPLES, SUITE 4105 BALTIMERE, MD 21204 JAN 1 3 201( 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per verb -, g899, 01/13/ Udhb Certificate of Death Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 3, 8:40  $P^{M}$ 2010 January Marie Ewing /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Broadmead** Cockeysville Baltimore 9. Birthplace (State or Foreign Country) Switzerland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 😾 F 218-38-4525 92 Feb.9, 1917 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be redified at once. 1 Yes 2 No Director Cockeysville MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13801 York Road Apt. L16 21030 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 white 1 ☐Yes 2 ☑No Specify. 2 Specify: 3 ₺ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Clothing unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecelia DeCourcy May Wilhelm vom Rath 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Ewing-son 33 Laurel Point Circle-Harpswell, ME 04079 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Druid Ridge Cemetery 11-8-10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel And Cremation Services 16924 York Road— Monkton, Maryland 21111 LME Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician hema Dubdu 20 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ O BSTRUSTIUE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown monar Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an Deepvenous 2 X No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation tal 1 ☐ Yes 2 No January 2,20 6 200 A M 12
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 4 🗌 Homicide Nursing Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) MDG wimple

State Registrar 31. Date filed (Month, Day, Year)

JAN 1 3 2010

Swing

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

iancy Lee Flan		1- For State		ment of Health ar Ticate of Death	ia Mentai H		2010	00435
Physici		1. Decedent's Name (First, Middle,Last)				Date of Death     Month	Day Year	3. Time of Death
Medical Exami	ner	Nancy Lee Frank  4a. Facility Name (if not institution, give street and not	umber)	4b. City, Town, o	r Location of Death	January 10,	2010 4c. County of Death	1050 hrs
		432 Ingleside Avenue		Catonsville			Baltimore Cou	
Funeral Director		5. Social Security Number 215-84-8606 6. Sex	7. Age (In yrs. last 50	birthday) If Under 1 Ye  Months Day			(MM/DD/YYYY) 9. Bir Foreig • 1959 Co	
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
Aaryland 28a-f show i at once.	or	MD Baltimore	Ca	tonsville				1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 432 Ingleside Avenue		10f. Zip Code	20		. Citizen of What Cou	ntry?
with th ns 23a e notif			cedent Ever in U.S.	13. Was Decedent of H			JSA 14. Race - Ameri	can Indian, Black,
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner myst be notified at once	by Funeral	1 Never Married 2 Married 1 Yes 3 Widowed 4 X Divorced If Yes, Give For pates:	2 X No ar	If Yes, specify Cuba	o specify:		White, etc.  Specify:	White
2 hours "natur Exam	ted	15. Decedent's Education (Specify only highest gra  Elementary/Secondary (0-12) College (		ia. Decedent's Usual Occupa during most of working life			6b. Kind of Business/I	ndustry
5-0036 led within 72 hours afti Tygiene, other than "natural" the Medical Examine	Completed	12	,	Homemaker			Own Home	e
		17. Father's Name (First, Middle, Last)	•			(First, Middle, Ma		
Z = 0 = 5	To Be	Milton Frank  19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Stre	et and Number or f		er, City or Town, State	
e, MD I and 2 sho Health and item 27 is			ther	432 Inglesid				
imore, MD 2 Pages I and 2 shou ment of Health and N lant: If item 27 is n or other traumatic		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal fr	om State crer	ce of Disposition (Name of ce natory or other place) ntic Cremator			20c. Location - City or	
Baltimore, permit. Pages I at Department of He Important: If ite injury or other tr		4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee	ACTA				Glen Burnionton Schwal	
Ba pern Dep Timp inju		Chekat	the	22. Name and Addres Funeral Ho 1630 Edmon	me of Car dson Aver	tonsville nue; Cato	e, Inc. onsville, M	1D 21228
Physician /Medical		23a. Part I. Enter the disease, or complications that of failure. List only one cause on each line.			, such as cardiac o	r respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
Examiner			one intox consequence of):	ication				Death
	_	Sequentially list conditions, if any, leading to immediate   Due to (or as a	consequence of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated						
uted Id iansit	Exa	overles resulting in deathly East	a consequence of):					
68760, certificate be executed nding physician and ise as the burial - transit	dica	UNPENDED AMENDED  IF FEMALE: 23c. If yes,	23a,27,2	8a-f,perME, g	899 1/25	/10 TT		
8760, ificate be ig physical	n/Me	23b. Was decedent pregnant in the	outcome of pregnan	cy Fetal death 3			23d. Date of delivery  Month	ay Year
Box 6876 death certifical the attending ph	sician/	past 12 months?	nant at time of death	5 Other (Specify)				
മെട്ടി	Physi			ting in the underlying cause	given in Part I.	23e Did toba	acco use contribute to	the cause of death?
Records, P.O. I The law requires that the cate has been signed by the page 2 should be detached.	d by					1 Yes	2 No 3 Prob	ably 4 🗸 Unknown
of Vital Records, ng Physician: The law require ther this certificate has been si	Completed			-		24a Was an autopsy	prior to c	opsy findings available ompletion of cause of
	S					perform 1 Yes 2		s 2 No
ion of Vital   tending Physician: eath. or: After this certifi	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1	Inpatient 2 ER	/Outpatient 3 DOA	Other <sub>4</sub> Nursin		esidence 6 🗸 Other	Scene
n of Ving Physics After the funeral	<u>'</u>	27. Manner of Death 28a. Date (Month	of Injury 28 , Day, Year)		ıry at Work?	28d. Describe how	v injury occurred	
Division Isl or Attendir Is after death. Is Director: A	catic	2 Accident Pending 1/10/		7.40 am ru		unk		- I D
Divis pital or At ours after d neral Direct filled in by	Certification	Suicide O (45) Could not be 1	house	, farm, street, factory, office	building, etc.	or Town, State Catons Vi.	e 32 Ingles	al Route Number, City Side AVE
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical C	29a. Certifier (Check only one) 2 Wedical Examiner: On the besing and manner series and manner series.	of examination and/o		ate and place, and	due to the cause(	s) and manner as state	d.
F % F 8	Me	29b. Signature and title of certifier	1	29c. Licens			9d. Date signed (Mor	
		lalmin		0.C.	M.E.		January 11, 2010	
151		<ol> <li>Name and address of person who completed cause</li> <li>Zabiullah Ali, M.D. Assistant Medic</li> </ol>	,	a) 111 Penn Street, Bal	timore, MD 21	201		
	ate	31 Date filed (Modth, Pay Year 2010 32	egistrar's Signature	1				
Regist		2010	was pl.	PICINAL				
OCME 2000			C	RIGINAL			OCME	

10-00049 Blanche Franklin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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		Registrar	Ce	rtificate of	Death		R	eg. No.	
Physicia edical Exami	an/ ner	Decedent's Name (First, Middle,La		-	1- 2		2. Date of Dea Month	Day Year	3. Time of Death 0146 hrs
-alcai Exami		Blanche 4a. Facility Name (if not institution, gi	Ettave street and number)		canklin o. City, Town, or L		January 3	4c. County of	
		Sinai Hospital			Baltimore				
Funeral Director		Social Security Number     6. S	3 . ,	ast birthday)	If Under 1 Year Months Days	If Under 24Hr Hours Mi	$\overline{}$		Birthplace (State or Foreign
Director		215-76-4334 1 Usual Residence of Decedent	м 28. г 51	Yrs.		1117	02 1	7 58	Country) MD
any		10a. State 10b. County	10c. City	, Town or Location	n		-		10d. Inside City Limits
and show nce.	or	MD NA		Balti	nore				1x Yes 2 No
te Maryland or 28a-f show any lied at once.	Director	10e. Street and Number	-		10f. Zip Code		[1	0g. Citizen of Wha	at Country?
death with the Maryland or items 23a or 28a-f sho must be notified at once.		5407 Wabash Av				215		U.S.	
ath wi	uneral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces?		Decedent of Hispa s, specify Cuban, I			- 14. Race - White,	American Indian, Black, etc.
fler de [", or	ш		1 Yes 2 No	1 🗍	Yes 2X No	specify:		Specify:	Black
nours a	ed by	15. Decedent's Education (Specify of		16a. Decedent	s Usual Occupatio st of working life. [	on (Give kind of	work done	16b. Kind of Bus	iness/Industry
36 in 72 h	plet	Elementary/Secondary (0-12)	College (1-4 or 5+)				(11 0 0)	No set been	ab Handa
5-0036 iled within 7 Hygiene. I other than the Medica	Completed	12th grade  17. Father's Name (First, Middle, Last	na )	nou,	sekeepi 		ne (First, Middle, f	Maiden Surname)	est Honda
21215 ould be file J Mental H. s marked o ic event, th	Be (	Rudolph Raigns				Bluma	Davis		
21 should nd Me is ma	٦	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailing	Address (Street a	and Number or	Rural Route Nun	ber, City or Town	, State, Zip Code) 21215
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Kevin Franklin 20a. Method of Disposition	-Husband 20b.	5407	Wabash	Ave t	Jnit #1 Date	, Balti	more, Md City or Town, State
Baltimore, vermit. Pages I an Department of Hea important: If iter njury or other tra		1 X Burial 2 Cremation 3	Removal from State	crematory or other	er place)				
litim nit. Pa artmer sortani		4 Donation 5 Other Specify 21. Signature of Funeral Service Lice			Chand Address of		13/201	b Mood]	lawn
Dep Dep III.		Kinetto K	· Imea	430	) Wabas	h Ave,	Balti	more, M	1d 21215
Physician		23a. Part I Enter the disease, or comfailure. List only one cause on e		. Do not enter the	e mode of dying, so	uch as cardiac	or respiratory arri	est, shock, or hear	t Approximate Interval Between Onset and
/Medical £xaminer		Immediate Cause (Final disease a or condition resulting in death)	Chest Injuries  Due to (or as a consequence of	0.					Death
		Sequentially list conditions, b	. Due to (or as a consequence of	nt).					
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/ _ =	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	f):				_	
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O, e be ex ysician burial	n/Medical	UNPENDED	AMENDED				-		
68760, certificate be nding physici se as the buri	N/U	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg	nancy <sub>2</sub> Feta	I death 3	Ectopic pregn	ancy	23d. Date of d Month	lelivery Day Year
Box 61 ne death cert the attendir	sicia	past 12 months?  1 Yes 2 No 9 ✓ Unknown	4 Pregnant at time of		er (Specify)				
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 94 hours after death. Funeral Director: After this certificate has been signed by the attending physician and lethy filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physiciar	Part II. Other significant conditions	9 Olikilowii	esulting in the un	derlying cause giv	en in Part I	23e. Did to	bacco use contrib	ute to the cause of death?
P.O. es that the igned by be detacl	질			<b>-</b>	,				Probably 4 Unknown
of Vital Records, P.C. ng Physician: The law requires that ther this certificate has been signed I	Completed						24a. Was		ere autopsy findings available
ecol he law ite has	ш	-		·			autop perfor	med? de	eath?  ✓ Yes 2 No
tal Rec cian: The certificate ector, page	B B	25. Was case referred to medical				f Death (Check			<b>7</b> 100 <b>2</b> 100
Vita hysici this c	일	1 ✓ Yes 2 No		ER/Outpatient					Other:
n of ding Ph After t funeral		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month Day Year) Jan 3, 2010	28b. Time of Inj 0114 hrs		at Work?		now injury occurred struck by auto	
Division ral or Attendir rs after death. al Director: A	icati	2 Accident Investigat	ion 28e Place of Injury - At h	ome, farm, street			28f. Location (S	Street and Number	or Rural Route Number, City
Division  Hospital or Attence 24 hours after death Funeral Director: stely filled in by the	Certification:	Suicide 6 Could not determine	be		,,	<b>-</b>	or Town S	tate)	e, Baltimore, MD
To the Hospital within 24 hours To the Funeral completely filled		29a. Certifier (Check only 1 Certifying Physic	ian: To the best of my knowled				d due to the caus	e(s) and manner a	es stated
To the Hos within 24 h To the Fur completely	Medical		r:On the basis of examination a and manner stated	nd/or investigatio			at the time, date		
	2	29b. Signature and title of certifier	11 000		29c. License i			January 3, 2	d (Month, Day, Year)
		30. Name and address of person who	completed cause of death /line	23a)	U.C.IVI		-	January 3, 2	
		Pamela E. Southall, MD	Assistant Medical Exa	miner 111	Penn Street,	Baltimore,	MD 21201		
	ate	31. Date filed (Month, Day 1)	20 02. Registrar's Signatu	ire A. A	artis				
Regist	rar	AMM 7 S	EUTO JEROM	1. 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 00437 State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 2010 12:50 A<sup>M</sup> January 8, Dorothy <u>Pavlakos</u> Gitsas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Future Care Charles Village Baltimore 8. Date of Birth (Month, Day, Year) Aug. 28,1922 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** Mary Land 1 M 2 X F Months Days Hours 87 **Director** 217-26-8782 Aug. Usual Residence of Deceden 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Director Examiner must be notified N/A 1XXYes 2 ☐ No Maryland Baltimore 10f. Zip Code ō 10e. Street and Number 10g, Citizen of What Country? 23a Charles Street 21218 U.S.A. 2327 N. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. ö <u>م</u> 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 X Widowed 4 ☐ Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Grade Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pavlakos Nicholas Estelle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl<sup>-</sup> Department of Health al Important: If item 27 is any injury or other trau Catherine Wagner/Sister 1 W. Conway Street, Apt.216 Baltimore MD 21201 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Date 01/11/2010 Greek Orthodox Cem. Baltimore MD Donation 5 Other (Specify) Charles S. Zeiler & Son, Inc. 6224 Eastern Ave. Baltimore MD 21224 21. Signature of Funeral Service Licenses complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between 23a. Part 1. Enter the disease shock, or heart failure Pro grassine Onset and Death Immediate Cause (Final Pnysician/ Dech disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Zonhow Sequentially list conditions if any, leading to immediate cause. Enter Unide lying Cause (Disease or iinjury Due to (or as a consequence for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial James Diseans Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn nordine P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 1 ☐ Yes 2 L g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Hiknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? Yes 2 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1  $\square$  Yes 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P31464

Registrar

State

Registrar's Signature

821 N. ENTAW ST SHITE 308

BALTIMORE MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STOALS A. HASTMIMD

JAN 1 3 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5,8, perFH, G900,2/4/2010, WS#7

State of Maryland / Department of Health and Mental Hygier | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Richard рм Goodman Jan.8,2010 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 8375 Sunset Dr. Ellicott City Howard 8. Date of Birth 1946 (Month, Pay, Year) 04/15/1945 If Under 1 Year | If Under 24 Hrs. 248Sa4249885 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1√2 M 2□ F <del>216-44-987</del> 64 63Yrs. Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural; or Itams 23a or 28a-1 show up or other traumstic event, I'm Medical Examine or matter notified at ury or other traumstic event, I'm Medical Examine or matter notified at 10d. Inside City Limits MD Howard Director Ellicott City 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8375 Sunset Dr. 21043 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Escavating Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Goodman Katherine Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nancy Lee Ewing/Sister 13 Carrington Road, Hendersonville, TN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 14 □ Donation 5 □ Other (Specify) Ardent Cremation Services | 01/12/2010 | Hanover, Maryland 21. Signature of Funeral Se Licentee 22. Name and Address of Facility Ardent Cremation Services 7522 Connelley Drive, Ste.N, Hanover,MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DISSECTION disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** frany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine CHOLEJIEROL Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit +1617 Due to (or as a consequence of): Box 68760. Physician/Medicai the use as IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ Be Completed Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performe 2 No 1 Yes director. 25. Was case referred to medical 26. Place of Death Check on one examiner' Other: 4 Nursing Home Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 2 Accord 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signarure and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar of death (Item 23a) (Type, Print)

address of person who completed care

01.12.10

ROAD LOLUMBIA MO ZIOYY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year ZOIO O TOOM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Tate Hospice House Linthicum Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland **Funeral** (Month, Day, Ye Year)1918 Months Hours Min 1 M 2 F 213-76-3933 Director Jan. Usual Residence of Decedent show 10a. State be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f Md. Queen Anne Stevensville 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 129 North Lake Dr. 21666 IISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Š 1 Never Married 2 Married 2 🛛 No 1 Yes 1 ☐ Yes 2 X No Specify: "natural", 3 → Widowed 4 □ Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) 9th College (1-4 or 5+) traumatic event, the Homemaker Household Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ J. Saffran George Margaret Runge t. Page 1 and 2 should by tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Hatch Jr. 140 North Lake Dr. Stevensville, Md. 21666 Department of Health Important: If item 27 any injury or other the 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) /15/10 Glen Haven Cem. Glen Burnie, Md re of Funeral Service Licen 21. Signatu 22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 23a. Part 1. Enter the disease, or coung shock, or heart failure. List only of cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.9 autopsy performed? 1 Yes 2 No \_ Yes

Be ٥ Certificate:

> Medical 29

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

1 ☐ Yes 2 ☑ No	Was case referred to medical examiner?

☐ Inpatient 2 ☐	ER/Outpatient 3	3 🗆 DOA	Other: 4 Nursing Ho	ome	5 Residence	6 Other	(Spe	cify	7
	28b. Time of injury	28c.			Describe how inj				

26. Place of Death (Check only one)

1 🗆 Yes	2	No	
Manner of D			
1-Natura	1	5 🗌	Pending

(Month, Day, Year)	injury M	work? 1 Yes 2 No	2
On Diana of Injury At he		u:	Т.

Residence	6 Other	(Specify)	20 14	DICE
escribe how inj			1 1	oust

MIK

2 Accident	Investigatio
3 Suicide	6 Could not b
4 Homicide	determined

f. Location (Street and Number or Rural Route Number, City or Town, State)

a. Certifier	1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
(Check	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and ma
only one)	3 Lettifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b.	Signature and title	of certifier	_
	DAMA"	chal	2
	7000	Colon	0

Henta	W	

29C.	License	number	_
	D	2143	8

29b. Signature and title of certifier  The signature and title of cert	29c. License number D 2143 8	29d. Date signed (Month, Day, Year)  Sonuary 12,7010
30. Name and address of person who completed cause of death (Item 23a) (Type, Pried) WILLER WILLER (Type, Pried)	EFENSE HIGHWAY A	NNAPOUS MDZ1401

State Registrar

31. Date filed (Month, Day, Year)

Hospital:

28a D



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5, perstare of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician Heard Sr. Edward Lee anuar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** altimore HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Numbe 219–26–8625 Date of Birth (Month, Day, Year) **Funeral** Months Min 1**X** M 2 □ F Director 68 MD 02 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 1XYes 2 No Director MD NA Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21205 U.S.A. by Funeral 502 North Lakewood Ave 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Tyes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2√∑No Specify. Specify: Black M☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) General Motors Assembly Line Worker 11th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Luradell Lay injury or other traumatic 2 Howard Heard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trains once. 502 North Lakewood Ave, Baltimore, Md 21205 Audra M Burrell-Daughter Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X□ Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Vet 1/20/10 Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as x onsequence of) Examiner Sequentially list conditions Examiner trans. leading to transcale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Prostate Cancer The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 ☐ Other (specify) ed by the a P.0. 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate | 1 ☐ Yes 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Magner of Death 1 Natural 2 Accident 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No al or Attendi after death. the 1 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital o within 24 hours aft To the Funeral Di 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar (Check only

31 Date filed (Month

29b. Signature and title of certifier

work

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ aacMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSIT OF Battimore Mac 100101 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8 Date of Birth **Funeral** 1 M 2 X F 03-02-24 217-22-7506 Director 82 Usual Residence of Decedent 28a-f shov 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD NA Baltimore 1 K Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 USA Mount Street Apt.#114 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc African Armed Forces? 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: American 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) NA Housekeeping Company unk. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Burrell Isaac Henry permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4101 Glen Arm Avenue Baltimore, MD 21206 William Bailey-Nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State King Mem. Pk. Cemi. 01-16-10 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. Gilmor Street Baltimore, MD 21217 638 N. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) the attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Day Month Year Pregnant at time of death detached P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has autopsy performed? Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \Bigcap \) Nursing Home 5 \( \Bigcap \) Residence 6 \( \Bigcap \) Other (Specify) 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of ë 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Certificat Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

csenblat

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore MD

10-00186 Sean Johnson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month January 7, 2010 **Medical Examiner** Sean Johnson 0645 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore 5. Social Security Number If Under 24Hrs. 8, Date of Birth(MM/DD/YYYY) 9, Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days Director Hours Min 03-9-1968 217-02-8171 MD 1 XM Country) 41 Usual Residence of Decedent any 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show 1 X Yes 2 No na Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. rector 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō USA 21218 2717 Tivoly Avenue Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes If Yes, Give Year Divorced Yes 21 No specify: Black Specify: Š 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) unemployed Unemployed llth grade na 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Sheila Johnson Grover Reid 19a. Informant's Name/Relationship (Type, Print ) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwendolyn Johnson -Wife Tivoly Avenue Balto, MD 21218 2717 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State King 1-13-10 Randallstown, Memorial Park 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H MD 21202 1101 E. North Avenue Balto, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Head Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last andtransi To the Hospital or Attending Physician: The law requires that the death certificate be executed sician/Medical UNPENDED **AMENDED** IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Year Month Day 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown F. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ Records, P. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? ✓ Yes 2 25. Was case referred to medica 26.Place of Death (Check only one) of Vital Be Hospital: 1 / Inpatient 2 Other<sub>4</sub> ER/Outpatient 3 DOA this Nursing Home 5 Residence 6 Other 1 Yes 28a. Date of Injury FOUND: Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject assaulted Natural FOUND: Pending 1 Yes 2 ✔ No Jan 4, 2010 1721 hrs Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 24 hours after 3 Could not be Suicide or Town, State) 1300 N. Milton Avenue, Baltimore, MD determined (Specify) Local Street 4 V Homicide Fo the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 8, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 31. Date filed (Month. State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 10, 2010 2:28 Barbara Jean Kimmell Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 2209 Redthorn Road Essex Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min. 07/13/1931 Mary Land **Director** 78 217-28-9404 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Baltimore Essex 1 Yes 2 XXIIo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 U.S.A. 2209 Redthorn Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ð 1 Never Married 2 Married ental Hygiene. Maryland 21215-0036 1 Yes 2XXNo Specify. Specify: 3℃ Widowed 4 □ Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Car Manufacturer Cashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Sines Dale Sines permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
611 China Clipper Circle, Baltimore, Maryland 21221 19a. Informant's Name/Relationship (Type, Pnint) William Kimmell (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gard. 01/13/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Eacility Ski Funeral Home, P.A rau 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER Physician/ VULVAR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 10 YRG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 9 Unknown Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 s autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page performed' Yes 2 N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 Yes 2 X No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending Division 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 043934 JANUARY 12, 2010

Registrar

Box 68760

P.O.

of Vital

State

31. Date filed (Mo.

PALIL

PLACE

BALTIMORE

MO

21202

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

227

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:08 P. M Stella Margaret Kazmarek January 8, 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Heart Homes Assisted Living Anne Arundel Linthicum 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days New York Hours 1 □ M 2 🕅 F 91 Yrs. 098 10 9172 03/29/1918 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Maryland Anne Arundel Severna Park Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Sullivan Drive U.S.A. 21146 Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
Int: If Hean Z Is marked other than "natural", or items 23, mir: If them 2 Is manafte event, the "Nedical Examiner must rry or other traumatic event, the "Nedical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ 3 K Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Motor Vehicle Adm. Secretary 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (not available) Mary Roman Gurski ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Kazmarek / Son 6206 Chestnut Oak Lane Linthicum, Maryland 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any Injury or o 1 L Burial 2 ☐ Cremation 3 ☐ Removal from State 01/13/2010 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemeterv 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Vear disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregna 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 2 N 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has be irector, page 2 s autopsy perform To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) nours after death.

neral Director; After this cer
filled in by the funeral direc Other: 4 Nursing Home 5 Residence 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 6 ⊟Other (Specif 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manuer stated.

within 2.

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

0

Registrar's Signature

death (Item 23a) (Type

29c. License number

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ For State	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No.	0 00445
			Registrar  1. Decedent's Name (First, Middle, L	Last) 2. Date of Death	3. Time of Death
	Physici /Medio		LOREDA	INT LAMPARITION JAN 11 20	10 3:30 PM
	Examir	ier	4a. Facility Name (If not institution, g	give street and number)  4b. City, Town, or Location of Death  4c. County of I	Peath ARD
	Funeral			Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 Months Days Hours Min. 4-23-1723	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	86 118. 4-23-1723	ITAZY
	hours after death with the Maryland tural", or items 23a or 28a-f show at Evantinet institue notified at	2	10a. State 10b. County	TUBED 10c. City, Town or Location E/KRIdge	10d. Inside City Limits 1 ☐ Yes 2 ☒No
	r 28a-f show	Director	10e. Street and Number	10g. Citizen of Wha	
	ath with	al D	5925 Ab	RIANNA WAY 21075 U.S	5. A.
	items	Funeral	11. Marital Status	Armed Forces? If Ye's, specify Cuban, Mexican, Puerto Rican, etc.) Black, V	American Indian, Vhite, etc.
5-0036	urs aft al", or Evani	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	d 1 □ Yes 2 Ø No If Yes, Give	White
15-0	"natural",	letec	15. Decedent's I (Specify only highest g	Education 16a. Decedent's Usual Occupation 16b. Kind of Busin (Give kind of work done during most of working life, DO NOT use retired)	ess/Industry
2121	withir giene. r than	Completed	Elementary/Secondary (0-12)	College (1-40r5+) Semstress House of	f Worsted Tex
	ges 1 and 2 should be filed within 72 ho t of Health and Mental Hygiene. If item 27 is marked other than "natu or other traumatic event, in Medican	Be	17. Father's Name (First, Middle, Las		clo;
Maryland	should nd Mer marke matic	မ	19a. Informant's Name/Relationship		tSTR1
	and 2 salth ar 27 is er trau		JOANNEWALKER	Custom M	Md 21075
ore	ges 1 au it of Hea lfitem or othe		20a. Method of Disposition 1 → Burial 2 □ Cremation 3	Removal from State   cemetery, crematory or other place)	y or Town, State
Baltimore,	t. Partmen rtant:		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	city) Mensowridge Cenetery: 1-15-2010 Elkridge	MARYLAND
Ba	Depar Impor any ir		1 full	Zan 2635. Conkling St. BAlto.	
İ			shock, or heart failure. List or	prolications that caused the death. Do not enter the mode of dying, such as car in c or respiratory arrest.	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	Onsoruna Baun
1	Examiner		Constant all to the constitutions	Due to (or as a consequence of):	
	ed sit	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequience of):	
΄,	e be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	c. BOLLOUS PEMPLAOLD  Due to (or as a consequence of):	
8760	cate be executed obysician and the burial-transit	dical		d	
Ó	certific nding p	/Mec	IF FEMALE:	23c. If yes, outcome of pregnancy	f dollyon
Box	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregulant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	•
P.O.	hat the ed by th	Phys	9 Unknown	s contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	te to the cause of death?
Records,	quires t n signe	d by			☐ Probably 4☐ Unknown
eco	law requir as been si 2 should l	Completed		24a. Was an autopsy prio	re autopsy findings available r to completion of cause of
al R	ding Physician: The law h. After this certificate has funeral director, page 2 s			performed?   dear	th? Yes 2 □ No
of Vital	/sician s certif lirector	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 4 DOA Other: 4 Nursing Home 5 Residence 6 Other	(Consider)
n of	ng Phy fter this	n: To	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work?  28c. Injury at Work?	Specify
Division	ttendi death. stor A	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	be an Dispersion Advanced to the first term of the second terms of	or Rural Route Mumber
Pi N	al or Attences are recently an expected in Director and in by the	Certification: To	4 ☐ Homicide determined	building, etc. (Specify)	r nurai nodie Namber,
	To the Hospital or Attending within 24 hours are death. To the Funeral Director: After completely filled in by the funer	Medical (	(Check only 2 Medical Exa	Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mann aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and	er as stated. due to the cause(s)
	To the vithin 2 omple	Med	29b. Signature and title of certifier	and manner stated.  29c. License number  29d. Date signed (h	fonth, Day, Year)
			C-SQ	(alt M) D0064539 Jan 11	14 2010
	10/		30. Name and address of person who	o completed cause of death (Item 23a) (Type, Print)	. 14.0
	Sta	te	31. Date filed (Month, Day, Year)	32) Registrar's Signature	1140
	Registr	ar	JAN 1 3 201	10 Very A hard	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ocuin 005 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NNA Polis If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Country) NY Days Hours 1 🛛 M 2 🗆 F 2757799 Director 90 132-05-1505 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🕱 No ANNAPOLIS MD ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21401 807 EASTERN POINT ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Saltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 🕅 No Specify: Specify: WHITE and Mental Hygiene. 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. POSTAL SERVICE POSTAL WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ LANG LOEWINGER HANNAH LOUIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 807 EASTERN POINT ROAD, ANNAPOLIS, MD 21401 CHERYL MEDVEDEFF / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State STARRETOY C'EDAY POTHER PLACE) MEMORIAL GARDENS 1 Burial 2 Cremation 3 A Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/14/2010 N. LAUDERDALE, FL Funeral Service Co 22. Name and Address of Facility SOL LEVINSON & BROS., INC. PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one deuse on each line. Immediate Cause (Final Onset and Death Physician/ Hrterio disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Dun to (or sele nonexpense of): Exami law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Box 68760 as t the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has page 2 or Attending Physician: The 1 ☐ Yes 2 ☐ No this certificate Yes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Hospital: Other: 2 No ြု 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a

To the Funeral C

completed filled the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10, 2010 3:40a M Elizabeth Ann Longley January Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice Care If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** April 1, 1926 1 M 2 XF Months Mary land 83 Director 217-26-2815 Usual Residence of Decedent 10d. Inside City Limits iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? I Hygiene. other than "natural", or items 23a Funeral USA 5703 Visitation Way 21210 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify White If Yes Give Specify: 3 Widowed 4 Divorced Completed Year or Dates. other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Home maker in home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fis marked of ဂ္ e e permit. Page 1 and 2 should be Department of Health and Meni Important. If item 27 is marke any injury or other traumatic Grace Cummings Herbert A. Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Stephen T. Longley Visitation Way, Baltimore, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State West Chester, PA 4 Donation 5 Other (Specify) 1/11/2010 A.Ferris & Company 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 21. Signature of Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Pnysician STOKE weekes disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** TRUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): that the death certificate be yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of ' IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day detached for Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown The law requires Records, peen s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 121No death? ementic within 24 hours after death. **To the Funeral Director:** After this certificate h Vascular 1 TYes 25. Was case referred to medical or Attending Physician: the funeral director, 26. Place of Death (Check only one) Division of Vital Other: 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) W 24 4 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in the property of the prop Hospital Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b, Signature and title of certifier 29c. License number 10,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARLIES Дау, 32. Registrar's signatur State Registrar

The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760 detached certificate To the Hospital or Attending Physician: After this funeral of Director: filled in by within 24 hours e To the Funeral C

**Funeral** 

Director

if item 27 is marked other than "neturel", or items 23s or 28e-f show or other traumatic event, the Madical Examinar must be notified at

Baltimore, Maryland 21215-0036

filed

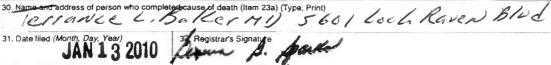
Mental H

permit. Pages 1 and 2 should be Depertment of Health and Mental Important: If Item 27 Is marked eny injury or other traumatic events.

**Physician** /Medical

Examiner

State Registrar 31. Date filed (Month, Day, Year) JAN 13 2010



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00449 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month McClura une 2010 16:02 PM Januaru Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bayview Medical Cente Baltimore Hopkins If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔽 F Months Hours Min (Month Day, Year) 18 Country) 195-07-5911 Director 91 PA Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d Inside City Limits within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director MD 1 Yes 2 No Point Dundalk Sparrows 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2825 Lodge Farm Road 21219 S 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc "natural", or 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3X Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Ioth grade College (1-4 pr 5+) n/a Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental ! Lawrence Wevoday Lonnie Markel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21219 item 27 is Donald P. Hildebrant-Son 2425 Lincoln Avenue Sparrows Point, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1-8-2010 Woodlawn Cem Harrisburg, PA Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H Wan 1101 Ε. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pulmonary Physician/ days disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner moriths Breast Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Voar Pregnant at time of death 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

Yes 2 No death? 1 Yes 2 No L\_ Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) 2 X No Other: မြ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Accident 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month. Dav. Year) KES - 000 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Strunk 4940 Eastern Are Baltimore 0 MD 21224

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

Division of Vital

32. Regitrar's Signature

State of Maryland / Department of Health and Mental Hygiene 00450 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month John Henry Messenger Jr 2010 12:34A M Medical lan 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 720 Earls Beach Road Baltimore Baltimore County Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 📈 M 2 🗆 F Hours 91 212 16 6017 Januar (\*\* 1919 Baltiffore Co.. Md. Director Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Balt.imore Baltimore County-Middle River 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 720 Earls Beach Road 21220 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 X Married Completed by ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give 3 Divorced 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Heavy Equipment Operator Martin Marietta Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mary E Drayer John H. Messenger Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
720 Earls Beach Road Middle River, Maryland 21220 Daisy B Messenger 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. January 11 2010 Baltimore, Maryland og al re of Funeral Service Licensee 22. NEASSAHN FUNERAL HOME 7401 BELAIR RD. BALT BALTIMORE MD. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ETASTA Onset and Death TIC CARCINDMA Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) 6 Months Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of, physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Vear 9 Unknown 9 Unknown ned by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 autopsy performed? After this certificate | 2 No 1 🗌 Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ပု 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined ร 24 hours a e Funeral โ Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stateu.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completed fi (Check only one) 29b. Signature and title of certifier D016728 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  $\theta_{\prime}$ 6830 HOSPITAL DRIVE BALT MD 21237 LAW 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

JAN 1 3 2010

ESSEN BAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Helen Emily McCorkle 6:39 AM 01 07 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Air Year | If Under 24 Hrs. | Harford Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) ocial Security Number 7. Age (In yrs, last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🛛 F Director 217-22-6641 82 02/27/1927 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Exampler must be notified at 1 ☐ Yes 2 No Director MD Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 164 E. Orange Court 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by Specify: 3X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bank Teller Union Trust Bank is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be f Health and Mental I William Penn ဥ Edith Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan E. McCorkle (daughter) 164 E. Orange Court - Baltimore, Maryland 21234 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If its any Injury or o once. 1 X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 01/09/2010 | Jarrettsville, Maryland Jarrettsville Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. assaln 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Condian ans disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated execute Physician/Medical Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): burial attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sate has been signed page 2 should be a 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1230 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perforn this certificate 1 ☐Yes 2 ☐ No hygekligip 1 □ Yes ā or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 区 ER/Outpatient 3 ☐ DOA Medical Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician MCDONALD JANUARY 2010 11:46 A M SHEILA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE NORTHWEST HOSPITAL RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12/31/1952 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🕱 F 171-40-3768 58 **Director** Pennsylvania Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Madical Examinar must be notified at 1 ∏Yes 21 No Director MD Baltimore Woodstock 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21163 U.S.A. 10117 Davis Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after dall Hygiene. Black White etc. 1 □Yes 2 ☑ If Yes, Give Year or Dates: 6 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐Yes 2√2 No White \$ Specify: 3 ☐ Widowed 4 🖾 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other tht any injury or other traumatic event, Italione. <u>Healthcare</u> <u>Pharmacist</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Russell McGuire Patricia Franklin မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jorge Santiago/Companion 10117 Davis Ave, Woodstock, MD 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 01/12/2010 Hanover, Maryland Ardent Cremation Services 🗄 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur f Funeral Servi Licensee 22. Name and Address of Facility Ardent Cremation Services 7522 Connelley Drive, Ste.N, Hanover, MD 21076 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 sign be 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an Physician: The 2 **X** No 1 □ Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending of thours after death.

Funeral Director Afterely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tile of D0060293 JANUARY 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 OLD COURT RD. RANDALLSTOWN AHMED M.D. 21133 31. Date filed (Month, Day, Year) 32. Registrar's Signa

DHMH 17 Rev 1/2001

Registrar

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Robert Jan	مع	, miller				
10-00162 UNK UNK		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.				
ONK ONK		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar  Certificate of Death Registrar	2010 00453			
Physicia	ın/	1. Decedent's Name (First Middle Last) 2. Date of Death	3. Time of Death			
Medical Exami	ner	Robert James Miller  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	010 1001 hrs			
	1048 Cedar Ridge Court  Annapolis  Anna Arundel					
Funeral Director		577-66-5432 1XM 2F 58 Yrs. Months Days Hours Min. 12/15/1	950 Pirithplace (State or Foreign Washington Country)			
any		Usual Residence of Decedent  10a. State	10d. Inside City Limits			
*	ė	MD Anne Arundel Annapolis	1 XYes 2 No			
ith the Mary 23a or 28a notified at	al Director	10e. Street and Number 1048 Cedar Ridge Court 21403	Citizen of What Country? U.S.A.			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 X Married 1 Never Married 2 X Married 2 X Married 3 Widowed 4 Divorced of Pises, Specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes, Give Year or Dates: 1 Yes 2 X No specify:	14. Race - American Indian, Black, White, etc.  Specify: White			
36 in 72 hours : han "natur! iical Exami	Completed b	46 5 4 5 4 6 4 6 7 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Bb. Kind of Business/Industry Plumbing/Heating			
5-00; ed with tygiene other t	Com	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maid	<u> </u>			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medical	å	Martin Miller Lucille Price				
AD 2 2 shoul 27 is m matic	٩	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number Elizabeth J. Kelly Miller/Wife   801 W. Covina Blvd., SPC 183				
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumant		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Commence of Commen	Oc. Location - City or Town, State			
timo t. Page tment o	ļ	4 Donation 5 Other Specify:	Hanover, Maryland			
Bal permi Depar Impol injury	1	21. Signature of Juneral Source Linesee  22. Name and Address of Facility Ardent Crema 7522 Connelley Drive, STe. N				
Physician	T	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line.				
Examiner	Ì	Immediate Cause (Final disease or condition resulting in death)  a. Intraoral Shotgun Wound  Due to (or as a consequence of):	Death			
		Sequentially list conditions, b.				
	caminer	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
ted nsit	Exan	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
executed ian and ial - transi	ical	d. UNPENDED AMENDED				
760, icate be physic the bur	Med	100h Mara da ad da at ara assat in the	23d. Date of delivery			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tra	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of 5 Other (Specify) 1 Yes 2 No 9 Unknown	Month Day Year			
P.O. B. that the de med by the detached f	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobac	cco use contribute to the cause of death?			
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death  31 Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ed b	1Yes 2	2 ✓ No 3 Probably 4 Unknown  24b. Were autopsy findings available			
Cord law rec has ber	Completed	autopsy performer	prior to completion of cause of death?			
ital Recician: The		25. Was case referred to medical 26. Place of Death (Check only one)	No 1 Yes 2 No			
of Vital Recing Physician: The After this certificate uneral director, page	To Be	Tes Z No	sidence 6 🗸 Other: Scene			
n of Nding Phy h		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury FOUND: 28b. Time of Injury Subject shot set 1 Yes 2 No Subject shot set 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Subject shot set 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No Subject shot set 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No No No No No No No No No No No No No				
/iSiO r Atten ter deat irector in by th	ficat	2 Accident Investigation   Jan 6, 2010   1001 hrs   Jan 6, 2010   28e. Place of Injury - At home, farm, street, factory, office building, etc.   28f. Location (Street, Factory)   et and Number or Rural Route Number, City				
Divisior Hospital or Attend 24 hours after death Funeral Director: tely filled in by the	Certification:	Suicide Could not be determined (Specify) Single Family Residence or Town, State 1048 Cedar Rige	Court , Annapolis, MD			
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and and manner stated.				
7 × × 5	ŝ	29b Signature and title of certifier 29c. License number 25	9d. Date signed (Month, Day, Year)			
		Curo Cyare Cycle	anuary 7, 2010			
10		Name and address of person who completed cause of death (Item 23a)     Victor Weedn MD JD				
	ate					
Regist	rar	JAN 1 3 2010 Rener B. garas				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 23a per dr., g899,01/13/10dhb

Certificate of Death

Reg. No. State Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 2010 Mary Ann MacFadyen January 2:45 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1922 Huguenot Place Severn Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 N F Months Days Hours Min (Month, Day, Year) ec 30, 1915 Country) Michigan Director 141-05-3609 94 Yrs Dec Usual Residence of Decedent 28a-f show 10a. State 10h County within 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 X No MD Anne Arundel Severn ò 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1922 Huguenot Place 21144 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 9 ģ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Black, White, etc. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: th and Mental Hygiene.
'7 is marked other than "natural", traumatic event, the Medical Exa Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Board of Education Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N unknown New Jersey Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carlo Rocchietti Domenica Gugliermetti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jean M. Nagy / daughter Huguenot Place, Severn, Maryland 21144 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Peter's Cemetery Jan 5, 10 New Brunswick, NJ St 21. Signature of Funeral Service 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road, Odenton, Maryland 21113 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Acute disease or condition months Medical resulting in death) Due to (or as a consequence of) Examiner Chronic Renal Insufficiency Sequentially list conditions, Examine cause. Enter Underlying Due to for as a son sequence of: Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has within 24 hours after death.

To the Funeral Director: After this certificate I performed? 2 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 M Natural 5 Pending iniury work? 2 🗆 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D50338

State Registrar xent Parkway

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11055

Registrar's Signatu

oblete

31. Date filed (Month, Day, Year)

JAN 1 3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00455 Reg. No 2 0 1 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** January 10, 2010 David Russell Miller <u>6:0</u>5 a <sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Harford Havre de Grace Jnder 1 Year | If Under 24 Hrs Social Security Number Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours **1√3**M 2□ F Yrs. Director <u> 153–16–3609</u> 88 October 29, 19|21 Maryland Usual Residence of Decedent 72 hours after death with the Marylan show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examinal must be notified at Director 1X Yes 2 □ No Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 904 Eugene Drive 21078 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tayes 2 □ No 1 fyes, Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🙀 Married Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced 1945 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Alice R. VanDyke David R. Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 Health Alice Mae Miller (wife) 904 Eugene Dr., Havre de Grace, MD 21078 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State R.A Ferris & Company 1/11/2010 4 ☐ Donation 5 ☐ Other (Specify) West Chester, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician acute on chronic respiraton disease or condition resulting in death) /Medical Due to for as a consequence of): **Examiner** Sequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-trar mat initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year Day 5 Other (specify) P.O. ed by the a 9 🗌 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn certificate Vital 1 ☐ Yes 2 1 ☐ Yes 2 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗖 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending 1 Natural 2 Accident 4 hours after death.

uneral Director: A
ely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and little of certif 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) [.] MiKityanskaia Ave. Houre de Grace, MD 21078 5. 501 Union

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00456 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 2010 JUSEPH NOVAKOWSK 8:37 PM MeLVIN 06 JAN Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMURE VA MEdICAL BALTIMURE Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-22-0290 Months Days Hours 84 Director **1**925 MD Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7146 GOUGH ST. UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1X Yes 2 \( \square\$ No Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify: WHITE If Yes, Give Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired)
CLOTH PROCESSOR Elementary/Seconday (0-12) College (1-4 or 5+) CLOTHING 12TH n Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ဂ permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev VINCENT NOVAKOWSKI GENEVIEVE ROMANOWSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANET ZIEGENHORN/NIECE 59 PINEHILL LANE, DELTA, PA Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ATLANTIC CREMATORY 01/14/2010 GLEN BURNIE, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC uso 6224 EASTERN AVE., BALTIMORE, MARYLAND 2122 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Complication of AbdomiNAL ADRTIC ANEURY SM Immediate Cause (Final Physician/ disease or condition resulting in death) dAY 3 Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the 튄 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown g Unknown Division of Vital Records, P.O. s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PNEUMON: A 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 4 No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ို 1 Inpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural iniury 5 Pending s after death.

I Director: Aft
d in by the fur 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours aff To the Funeral Di completed filled in Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 08

State

Registrar

DHMH 17 Rev 7/2009

Kathleen

31. Date filed (Month, Day, Year)

33. Registrar's Signature

30. Name and address of person who completed cause of death (I)em 23a) (Type, Print)

10NGReene Street Brutimore MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 10, 201 ar WILLIAM NEIDHARDT 5:35 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FOREST HILL HEALTH & REHABILITATION HARFORD FOREST HILL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** g. Birthplace (State or Foreign June 7,1931 **X** ⋈ 2 □ Hours **Director** 215-28-4916 Maryland 78 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Harford Maryland Pylesville 1 🗌 Yes 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 551 St. Mary's Rd. 21132 USA 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify. 3 Divorced 4 Divorced Completed White Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) lith and Mental Hygiene. 27 is marked other than r traumatic event, the M mentary/Seconday (0-12) Manufacturing 10th grade Machinist Industry Be Department of Health and Mental H Important If flem 27 is marked oth any injury or other traumatic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Leonard William Neidhardt Elizabeth Marie Bever 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret C. Neidhardt (Wife) 551 St. Mary's Rd. Pylesville, Md. 21132 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Pk. 1-13-10 Baltimore. Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee <sup>22</sup>Lassahn Fuheral Home, 7401 Belair Rd. Balti Inc. assal Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Due to (or as a c | sequence of): Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be exec Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? (0PD 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available CVT cate has bage 2 s autopsy performed? Yes 2 No prior to completion of cause of death? ours after death.

eral Director: After this certificate I filled in by the funeral director, page 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 2 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funeral Completed filled is Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 032255 JANUACY 11, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

DAVID DUNN

31. Date filed (Month, Day, Year)

W. MACPHAIL

ROAD

BEL AIR, MD. 21014

615

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year George 202 AM Joseph Neukam 2 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rosedale FRANKLIN SQUARE HOSPITAL CENTER Bactimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 ☐ F Days Hours 215 22 5600 11/14/1928 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2208 Poplar Road 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 □ No If Yes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Specify: White WW II 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Foreman ARMCO Steel Co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Geoerge M. Neukam Thelma Baker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Neukam (wife) 2208 Poplar Road Essex Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Bayview Crematory Inc 1/12/2010 Baltimore Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA eral Service 1407 Old Eastern Avenue Essex Maryland 21221 23a. Pa t1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediat Cause (Final Due o (or as a consequence of): in Farction disease or condition resulting in death) heart disease coronary Due to (or as a consequence of). Diabetes Due to (or as a consequence of) pertension 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify)

Physician /Medical Examiner

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funeral director, page 2 should

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Certification: To

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Physician

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show amy injury or other traumatic event, I'm Mydical Examination and once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Physician/Medical Examiner To the Hospita or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit

21. Sign

Sequentially list conditions, if any, learning to limited late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed

examiner? 1 Yes 2 No

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown

24a, Was an autopsy 2 No 1 □ Yes 26. Place of Death (Check only one)

Balto

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

2/. Manner of Death	
1 Natural	5 Pending
2 Accident	investigatio
3 Suicide	6 Could not b
4 🗌 Homicide	determined

25. Was case referred to medical

1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) ation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only
one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Square DR

29c. License number

29d. Date signed (Month, Day, Year)

md

21237

DRMichael 13 Pipkin 31. Date filed (Month, Day, Year)

9000 FRANKLIM

32 Registrar's Signature

State Registrar

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryiand 			t of Hea e of Dea			giene Reg. N	2010	00459																		
	Physicia		1. Decedent's Name (First, Middle, La Kenneth G.	•	s Sr					2. Date of De Januar			3. Time of Death 09:30 AM																		
	Medic Examin		4a. Facility Name (if not institution, give				4b. City,		ation of Death			c. County of Deat																			
	Funeral Director		215-07-7052		e (In yrs. last	birthday) 2 Yrs.	If Unde Months	1 Year If U	Inder 24 Hrs.  Durs Min.	8. Date of Bir (Month, Da May		9. Bir	thplace (State or Foreign untry) MD																		
	and show at	or	Usual Residence of Decedent  10a. State 10b. County		10c. City, 1	Town or Loc	cation						10d. Inside City Limits																		
	Maryla 28a-f s otified	Director	Maryland Anne A	rundel				Pasa	idena				1 ☐ Yes 2 🙀 No																		
	ith the		10e. Street and Number 2070-A Kurtz Ave	nuo			10f. Zip		21122		10g. C	itizen of What Co	-																		
	pe 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. V	Vas Deced f Yes, spec	ent of Hispan		ecify Yes or No- Rican, etc.)		USA 14. Race - Ame Black, White	rican Indian,																		
036	rs after rral", or Exami	ed by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 X If Yes, Give Year or Dates.	No	1	☐ Yes	2 ☑ No Sp	ecify:			Specify:	White																		
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212	within giene. er tha t, the N		Elementary/Seconday (0-12)	College (1-4 or 5	+)	ille. DC	Shop	Forem	nan		υ.	.S. Coas	t Guard																		
Maryland 21215-0036	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) Richard Franklin	Phelps						e (First, Middle, Henkel	Maiden	Surname)																			
lary	should be file n and Mental I <b>7 is marked c</b> raumatic eve		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailin	ıg Address	(Street and N	lumber or Run	al Route Numbe	r, City o	r Town, State, Zij	Code)																		
e, N	and 2 steem 27 steem 27 sther tr		Bonnie Dausch  20a. Method of Disposition	(daught		2070 ce of Dispos						1D 21122 ocation - City or																			
Baltimore,	Page 1 ment of I ant; If it ury or o		1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Con		cem	netery, crem	natory`or o	ther place)	Jan. 20			•	Maryland																		
Balt	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Sawiou Licen		7 11001		. Name an	d Address of	Facility	Stall	ling		al Home, P.A.																		
H			23a. Part 1. Enter the disease, or corr shock, or heart failure. List only of	pplications that caused	the death. I	Do not ente						ila, IID 2	Approximate																		
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a			my	NA					Interval Between On, et and Death																		
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	ed	Examiner	Sequentially list conditions, that y leads to transciate cause. Enter Underlying Cause (Disease or linjury	Due to for each	núnsagaion	ice sty																									
	icate be executed physician and s the burial-transit	i Exa	that initiated events resulting in death) Last	c. Due to (or as a	consequen	ce of):																									
200	cate be physici s the bu	ledical		d				<u> </u>																							
Box 68	ath certif attending for use a	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 1 Pregnant at 9 Unknown	2 🗌 Fetal d	eath 3 _	Ectopic p Other (sp					23d. Date of del Month	livery Day Year																		
ls, P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions of	contributing to death bu	ut not resulti	ing in the ur	nderlying (	ause given in	Part I.				the cause of death?																		
Records,	The law req ate has bee page 2 sho	Completed	omplete	Somplete	Somplete	Complete	Somplet	Complet	Complet	Complet	Complet	Complet	Complet	Complet	Complet	Complet	Complet	Complet	Complet	Complet			-							prior to death?	topsy findings available completion of cause of
	ysician: The lar is certificate ha director, page 2	Be	25. Was case referred to medical examiner?  1  Yes 2  lo	Hospital:				Other	f Death (Checi																						
of <	ng Phys ter this neral di	te: To	27. Manner of Death  1 Natural 5 Pending	1 ☐ Inpatie 28a. Date of injur (Month, Day	y 28	NOutpatien  Bb. Time of injury		Bc. Injury at work?	L Hursing Ho	ome 5 - Resid 28d. Describe h		6 ☐ Other (Spec ry occurred	ify)																		
Division of Vital	ttendir death. ctor: Af y the fu	Certificate:	2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not be	n De 280 Place of Inju		-	M et facton	1 🗆 Yes	2 🗆 No	20f Lagation /C	`4	ad Museelson on Pro	ral Route Number,																		
Ž	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director, After th completed filled in by the funeral		4  Homicide determined	building, etc.	(Specify)					City or Tow	n, State	2)																			
	ne Hospital on 24 hours a le Funeral Dieted filled i	Medical	(Check 2 Medical Exam	rsician: To the best of r iner: On the basis of ex se Practioner: To the b	amination ar	nd/or investi	igation, in i	ny opinion, de:	ath occurred at	t the time, date a	nd place	e, and due to the o	cause(s) and manner stated.																		
	To the within To the Complex C	72	29b. Signature and title concertifier	Ju	Sun	>	29c	License num	1036		29d. Da	ite signed (Month	n, Day, Year) )/c																		
	•		30. Name and address of person who	completed cause of de	ath (Item 23	Ba) (Type, Pr	rint)	ut Dr	(he	Chos	er.	m) j	16/9																		
L	Stat		31. Date filed (Month, Day, Year)	2010 32. Regidiral	's Signature	6	1				ι	-																			

State Registrar DHMH 17 Rev 1/2001 OCME 2006 30. Name and address of person

31. Date filed (Month, Day, Year)

Russell Alexander MD

32/Registrar's Signature

completed cause of death (Item 23a)

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per DVR g899 1/12/10 TT
State of Maryland / Department of Health and Mental Hygiene 0 1 0 Certificate of Death 1. Degedent's Name (First, Middle, Last) 2. Date of Death Year Day **Physician** arrette tacher 01 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE BALTIMORE COURTLAND GARDENS | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 03/05/1919 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months 1 ☐ M 2 1 F 90 205-10-3217 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "naturar", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No RANDALLSTOWN MD Director BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21133 USA 3801 SCHNAPER DRIVE by Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify: Specify: 3XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER** CITY OF BALTIMORE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FISHEL SAMUEL STEIN LENA ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUE CRAWFORD/DAUGHTER 2831 COX NECK ROAD, CHESTER, MD 21619 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. cemeters (remators a rather place)
ANSHE KURLAND CEM. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 01/10/2010 BALTIMORE, MD 4□Dgnation 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Funeral Service Lice 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 15min /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → nknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Ż⊠ No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 744817 07 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunlip Rajani, MD 2434 W. Belvedere Avenue Baltimore, MD 21029

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** II: iD A M Reid 2010 Johnathan 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Date of Birth 7–23–1949 Birthplace (State or Foreign **Funeral** 60 1**X** M 2□ F Months Min. S.C. Director 249-92-1130 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 X Yes 2 □ No Director n/a Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 U S Α 638 Barlett Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0036 Black 1 ☐Yes 2X No Specify: þ 72 hours 3 ☐ Widowed ★★Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pe<sup>-</sup>mit. Pages 1 and 2 should be filed within 5 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) <u>12th grade</u> Maryland; 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Reed Elizabeth Matthews မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia Gilliam-Sister 638 Barlett Avenue Balto, MD 21218 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Garrison Forest 1-14-2010 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee ladi Balto, MD 21202 1101 E. North Avenue Warren 23a. Part1. Enter the disease, or comp ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia **EDMOQUED** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed physician ar s the burial-tr Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

m.D. VA Maryland Health Care System, Perry Point, MD 21902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00463 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Day Dorothy Mae Steele ам Medical 2010 20 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sandtown N/H Balto 5. Social Security Number 7. Age (In yrs. last birthday) 76 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-5-1933 6. Sex **Funeral** 9. Birthplace (State or Foreign Days Months Hours Min. 1 □ M 2 F Country) Director 577-48-1284 DC Usual Residence of Decedent ms 23a or 28a-f shov must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director MD N/A 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 628 Perkins Street 21201 U S Α 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. th and Mental Hygiene. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner. 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🔀 No Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black If Yes, Give 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) unk Elementary/Seconday (0-12) College (1-4 or 5+) Nurse 12th na grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Eluscious Jones Meredith Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Johnny Jones -Son</u> Balto, Hawthorne Road Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Mt Zion Cemetery | 1-12-2010 | 4 Donation 5 Other (Specify) Lansdown, MD 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 1. Enter the disease, or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme to te Cause (Final DEMENTIA Physician/ dis or condition o or condition Medical Due to (or as a consequence of): Examiner RDIOMTOPATHY Sequentially list conditions, Examiner if any leading to immedicause. Enter Underlying ABE Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ျ 1 Tes 2/ No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

the Funeral Director, A suppleted filled in by the fu Investigation Accident 6 🗆 3 ☐ Suicide 4 ☐ Homicide Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) THENDING 2010 34625000 JAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print BARTINSME NO Sur PE Taminan 31. Date filed (Month, Day, Year) 32. Registr P's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #17 per FH g899 1/13/10 TT / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician**  $a^{M}$ Spinella Catherine J. 5:30 January 12 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Timonium Stella Maris Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/11/1922 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 😾 F 101-14-4304 87 Director Usual Residence of Decedent 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Position Examiner must be notified at Timonium 1 XYes 2 No Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21093 2300 Dulaney Valley Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ∐Yes 2 LaNo Specify: White ò 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, Ite Mo Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kirsch Katherine <del>Vacchio</del> Vecchio ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11 David Luther Ct., Hunt Valley, MD 21030 J. John Spinella / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Woodbine, MD Final Journey Crem. 1/13/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Dorota Marshall Maryland Cremation Services

23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of lying, such as car liac or respiratory arrest,

Approximated Cause (Fine) Approximate Interval Between Onset and Death Mi rieschoche Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed and burial-trar Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) O. 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 12/25/22 N3/1/12 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Striknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? certificate | 1 ☐ Yes 2 ☐ No 1 □Yes 2 No Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Be Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To o 27 Manual of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Division + tural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of bertifier 29d. Date signed (Month, Day, Year) 29c. License number JANUARY 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 EDDIE NAKHUDA, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 3 2010 Denus S. parket Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

2010

JANUARY

SPINELLA

CATHERINE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Month Year O 735UM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Annapolis <u>Anne Arundel Medical</u> Center 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗷 F Months Days Hours 116-22-0242 80 Pennsvlvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Beuufort Washington 1 🗌 Yes 2 🔀 No NC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 27889 103 Riverview Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Norma King Richard Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Riverview Drive, Washington, NC Fabyan R. Saxe/Spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cometery, crematory or other place)
Ardent Cremation Services 01/12/2010 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State Hanover, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service Lifensee 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) ra ue to (or as a consequence of) Sequentially list conditions, if any, leading to immedia cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of. that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months? Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 26. Place of Death (Check Be B

Physician/ Medical Examiner Examiner

Physician/

**Examiner** 

Funeral

Director

or 28a-f shov

item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at

and Mental Hygiene. is marked other than

Page 1 and 2 s ment of Health a tant: If item 27 i

Department of I Important: If it any injury or or once,

filed within 72 hours after death with the Maryland al Hygiene.

Baltimore, Maryland 21215-0036

been signed by the a lending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the dea h certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a ending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur

잍

Certificate:

Medical

Division of Vital Records, P.O. Box 68760

	Month	Day	Year
23e. Did tobacco us			of death?
24a. Was an autopsy performed?	prior to death?	utopsy findi completion s 2  No	ngs available of cause of
only one)			
me 5 Residence 6	Other (Spe	cify)	
28d. Describe how injury	occurred		
28f. Location (Street and City or Town, State)	Number or Ru	ural Route I	lumber,

29a. Certifier	1 Certi
(Check	2  Medi
only one)	3  Certi
29b. Signature	and title of ce

1 ☐ Yes 2 No

5 Pending

Investigation 6 Could not be

determined

examiner?

27. Manner of Death

1 Natural

2 Accident
3 Suicide
4 Homicide

fying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. cal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. fying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28a. Date of injury (Month, Day, Year)

Hospital

Other:

1 ☐ Yes 2 ☐ No

28c. Injury at

29d. Pate signed (Month, Day, Year)

cluse of death (Item 23a) (Type, Print) s of person who completed DEPENSE HIGHWAY ANNAPOLISMDLIYOU 6

State Registrar

Day, 32. Registrar's MAN 13

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

iniury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10Sullivan Robert Joseph January 2010 4:35 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 455 Basil Avenue Chesapeake City Cecil 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Hours Min (Month, Day, Year) 2/10/194 New Jersev Director 140-32-9266 67 Usual Residence of Decedent "natural", or items 23a or 28a-f show edica Examiner must be notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Cecil Chesapeake City 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 455 Basil Avenue 21915 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Black, White, etc. Completed by 1 Never Married 2 X Married X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 
Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Pest Control Exterminator\_ 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cornelius Sullivan Elizabeth Linahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.0</u> item 27 455 Basil Avenue, Chesapeake City, MD 21915 Linda Sullivan / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit, Page 1
Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 1/12/2010 Anatomy Gifts Registry Hanover, Maryland 4 X Donation 5 C Other (Specify) 21. Signature of Funeral Septe Licens 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death LUNG Physician/ CARUNOHA Medical resulting in death) Due to (or as a consequence of): \_ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and I for use as the burial-transit Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day signed by the at d be detached for 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPER TENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed should ATMIN FIBRIllation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 X No Yes 1 Tyes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: ည 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending Accident work 1 Tes 2 🗆 No Investigation s after deat Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Xertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie

within 24 hor To the Fune completed fi 29d. Date signed (Month, Day, Year) D0065733 D MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1476H V-PULA Smet BAST ELK TON HD U921 126 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ O Day 2º10 08:15 AM Medical acility Name (if not institution, Altimare) give street and number Town, or Location of Death **Examiner** AIDE. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🕱 F Days Hours Min. (Month, Day, Year) Director <u>230-26-1095</u> 85 06 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location irector 10d. Inside City Limits 1 ☐ Yes 2 X No MD Howard Columbia 靣 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21045 5650 Waterloo Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City College (1-4 or 5+) 4yrs+ Elementary/Seconday (0-12) 12th grade School System Teacher HEVENSON 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maude Stokes Freddie Chappell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Stevenson Whitaker Oueenstown Road, Severn, Md 21144 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 1/9/10 4 Donation 5 Other (Specify) Woodlawn Woodlawn, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, 21215 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Poxic disease or condition Medical resulting in death) Due to (or s a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last r Attendir g Physician: The law requires that the death certificate be executed mobar and burial-trar Due to (or as a consequence of) attending physician Physician/Medical Box 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Po Day Month Year Pregnant at time of death sate has been signed by the page 2 should be detached Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 To the Funeral Director: Af er this certificate of completed filled in by the funeral director, pag 1 🗌 Yes 2 🗌 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Tyes Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5  $\square$  Pending death. 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) fter determined Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number M.D. 01/03/2010 D0016248 Hagu. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 21201 ATNAFAL MD -300 Suite 3I 32. Resistrar's Signature 31. Date filed (Month,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 00468 State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JA₩ÜÄRY 2010 SAVAL 8:25P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GILCHRIST HOSPICE CARE TOWSON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpic Country) PA **Funeral** 1 D M 2 X F Hours 5/25/1914 **Director** 220-07-3227 95 Yrs. Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at death with the Maryland Director 1 ☐ Yes 2 💢 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7203 ROCKLAND HILLS DRIVE, #210 USA 21209 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or Completed by 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) STORE OWNER CHILDREN'S CLOTHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **JAFFE** BROWN ESTHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau RONALD COOPER / SON 11-A FRIENDWOOD COURT, BALTIMORE, MD 21209 Baltimore, 20b. Place of Disposition (Name of AN SHE EMUNAL Prother place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/12/2010 BALTIMORE, MD 21. Sig ature of Funeral Service L cen ee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition months Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (of as a consequence of) sician and burial-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) 9 Unknown been signed by the should be detached Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in 🖊 art I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform 2 🗌 No 1 🗆 Yes or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 \( \subset No. ျ 1 Inpatient 2 ER/Outpatient 3 DOA Hospics 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at After injury 1 Natural
2 Accident 5 Pending October 30, 2009 UNKNOWN 1 Yes 2 XNo within 24 hours after death

To the Funeral Director: A
completed filled in by the f Investigation her hend 00 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7203, Rockland Hills, IST WALL, P. KSVILL, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🛣 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sut, CRNP R149194 11,2020 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grant 6701 Towson MD 21204 Charles 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7:45 A M Robert Thewes J<u>anuary</u> าด์ 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 1 Months Davs Hours (Month, Day, Year) 3/29/1960 Country)
Washington, D.C Director 217-72-1778 49 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Tyes 2 X No MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b. Funeral 9535 Cissell Avenue 20723 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Specify 3 - Widowed 4 X Divorced Completed Year or Dates Decedent's Education. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Chef Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thewes William Ruth Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Thewes / Brother 9539 Cissell Ave., Laurel, MD 20723 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 1/12/2010 Hanover, Maryland 21. Signature of Funeral Server Lice see 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final nget and Death Physician/ disease or condition resulting in death) Medical Due to (or # a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the burial-tran signed by the attending physician and deetached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown g 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be Records, 3 ☐ Probably 4 ☐ Unknown 1 Yes been Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 Yes Hospital or Attending Physician: 25. Was case referred to edical examiner? Division of Vital funeral director, Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Mann f Death 28b. Time of Certificate: 28c. Injury at injury Natural 5 Pending work?
1 Yes 2 No Investigation after death Director: A Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d, Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Month Day Year **Physician** 3:12 a M 2010 January 8, R. Toney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Prince Georges Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03–07–1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F 93 Virginia Director 579-05-5953 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nature?" any hipty or other traumatic excent any hipty or other traumatic excent. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State P.G. Capitol Heights Y Yes 2 □ No **Funeral Director** Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1001 Cypresstree Place 20743 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Black þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laundry U.S. Soldiers Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Crump Sally Jones ဂ Percy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Violet Quattlebaum - Daughter 1001 Cypresstree Place, Capitol Heights, Md. 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 01-15-2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Ronald Taylor II Funeral Home 10583 Middleport Lane, White Plains, Md. 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Terminal Aspiration disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Bradycardia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the burla Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 □ Yes 2 ☑ No Month Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>چ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1₺ Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 9, 2010 D0069669 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Anupama Neelakanta — 3001 Hospital Drive, Cheverly, Maryland 20785

Registrar

State

31. Date filed (Month, Day, Year)

parked

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** DS30 AM 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner araallstown
der 1 Year If Under 24 Hrs. Medical lenter 7. Age (In yrs. last birthday) If Under 1 Year r 24 Hrs. Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign 6. Sex Security Number **Funeral** Days Hours Months 1**⅓**-M 2□ F 30-5609 Caroline. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exterior must be redified at 1 Yes 2 No Director ochearn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3674 U.J.A. barden 21201 by Funeral death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: Black Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Laborator 1anug 12 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Nymber, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) t of Health a Deloris 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Department of Important: If it any Injury or o once. Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ine. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) has been signed by the 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha 2 🗹 No 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 D Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 💟 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Date signed (Month, Day, Year) License number 29b. Signature and title of certifie

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Physician amson 2010 /Medical 4b. City, Town, or Location of Death Ac. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 9-25-1956 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Sex 1 M 2 □ F **Funeral** 244-98-6547 53 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or 28a-f show must be notified at 1 Yes 2 No Director Fort Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 4401 Payne Drive 20744 US items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 11. Marital Status other traumatic event, the Medical Examiner 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Black ģ Specify: 3 Widowed 4 Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If flem 27 is marked other than any injury or other traumatic event the Manay injury or other event the Manay injury or other event the Manay injury or other event the Manay injury or other event the Manay injury or other event the Manay injury or other event the Manay injury or other event the Manay injury or Elementary/Secondary (0-12) College (1-4 or 5+) Disabled 12th grade Disabled vear 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hubert Williamson ၉ Ruth Jacobs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sherri White-Williamson 4401 Payne Drive Fort Washington, 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1-14-10 4 ☐ Donation 5 ☐ Other (Specify) Sand Hill Spring Lake, N.C 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee l adu 1101 E. North Avenue Balto, MD21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consquence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed that initiated events burial-trar resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death
9 Unknown Month Day Year 5 Other (specify) 2 No PO. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by of Vital Records, 2 No 3 Probably 4 Unknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28b. Time of Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division or Attending 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 No rector: 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide in by 1 4 - Homicide filled within 24 hours
To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 600 North Wolfe St, Baltimore, MD, 21287 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2:19 AM **Physician** Vella 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2**½** F Yrs 9-24-1920 VA Director 220-078959 89 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show event, the Medical Examiner must be notified at MD N/A Baltimore 1 XYes 2 No Director 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number or items 23a or 2544 E. Eager Street 21205 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black Š 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore City College (1-4 or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Public School Cusdodian n/a 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Phillip Stokes Nannie Brown ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health : Brenda Pryor -Daughter Balto, MD 21205 918 N.Luzerne Avenue permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 1-8-2010 Crownsville, MD Crownsville Vet 4 Donation 5 Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Fungral Service License 1101 E. North Avenue Balto, MD 21202 Approximate Interval Between Onset and Death 23a. Part Part Enter of disease, or complications that caused to shock, or he at failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest immediate Cause (Final disease or condition DOWEL DELFORA Due to (or as a donsequence of): **Physician** resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Box 68760, Physician/Medical or Attending Physician: The law requires that the death certificate be IE EEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) Yes 2 No P.O. Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. þ Division of Vital Records, director, page 2 should be 2 **N**No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 🗌 Yes 2 No 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 \sum Nursing Home 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ည this filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28h. Time of 28d. Describe how injury occurred Certification: After (Month, Day Yeer) 5 Pending investigation 1 Natural 1 Tes 2 No death. To the Hospital or Attendia within 24 hours after death. To the Funeral Director, At 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1111 RES - DOC

Registrar

BEKKELEY

31. Date filed (Month, Day, Year)

10

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

LIMKETKAT

2010

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G899, 1/14/2010, WS
State of Maryland / Department of Health and Mental Hygiene
tems 10e, f per fh g899 (1-27-10 yt
Certificate of Death

Reg. No. 1- For amend Registrar items Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 632A **Physician** 2010 anuary ar 12 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Sex W∏M2□F **Funeral** Days Hours 220-03-6248 Yrs 11-29-1921 88 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show must be notified at 1 X Yes 2 ☐ No Director MD n/a Baltimore 10e. Street and Number

Bartlett 10f. Zip-Code 10g. Citizen of What Country? 0 21218 items 23a 608 Avenue Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural" one. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married African-American 1 ☐ Yes 2 No Specify þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Motor Pool Operator Edgewood Arsenal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Wilson Annabele Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia E. Wilson / Daughter 9109 Meadowheights Road, Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1/22 / 2010 XBurial 2 Cremation 3 Removal from State Garrison Forest Veterans Donation 5 - Other (Specify) <del>1-22-10</del> Owings Mills, MD 22. Name and Address of Facility Wylie Funeral Horms of Balto. Co. 21. Signatu of Funeral Service Licensee 9200 Liberty Road, Randailstown, MD 21133 Approximate Interval Between Onset and Death 23a. Part V. Enter the disease, or complications that cau / d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ocurdia /Medical **Examiner** Tensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner (gr as a consequence of) or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Tectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 25 1 Yes 2 No this certificate 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home Hospital: 1 Inpatient ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred filled in by the funeral 27. Manner of Death Medical Certification: 5 Pending investigation After Injury Matural 1 Accident 1 Tyes 2 🗌 No death. after death 3 🗌 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined To the Hospital of within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 24-00 anvary completed cause of death (Item 23a) (Type, Print) address of prson who 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar arks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2010 11:26 A M Ruth A. Walters January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 719 Maiden Choice Lane BRT-41 Baltimore Catonsville 8. Date of Birth
(Month, Day, Year)
July 17, 9. Birthplace (State or Foreign Country) Pennsylvania If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday **Funeral** Min. 1 M 2 7 F Hours 211-22-0436 80 1929 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown amy injury or other traumatic event, the Medical Examiner must be notified at once. 28a-f shov 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a State Director 1 Yes 2 No MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21228 719 Maiden Choice Lane BRT-41 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: White Specify: 3 ₩ Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Anna E. Rozitus Elmer T. Everett, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2003 Tadcaster Road; Catonsville, MD 21228 Jane Philipowitz Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem. Garden 1/14/2010 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signature of Funeral Service Licens 1630 Edmondson Avenue: Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and sthe burial-transit death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 mopths?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 9 Unknown been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Pres 2 No 3 Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autonsy performed 1 Yes 2 No Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred e Hospital or Attending P n 24 hours after death. e Funeral Director: After t (Month, Day, Year) 1 Natural
2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Practioner: To the best of my knowledge, drath occurred at the time, date and black, and due to the data-(s) and manner as stored only one 29b. Signature and title of certifier Type, Print)
and on Chance Cane, Catendorle Mayor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

ans

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 238 tate of Maryland / Department of Health and Maryland / Department of Health and Maryland Hygiene Registrar Certificate of Death Reg. No. 00476 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Wright ling 3:58 PM 2010 Medical anyar 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 29 Hurbor Hospital 3001 5. Hanover Baltimore 5. Social Security Number 217–66–2872 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗆 F Months Days Hours Min. Country) Director 54 Usual Residence of Decedent Fshow 10a. State 10b. County iral", or items 23a or 28a-f shorexaminer must be notified at within 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits MD Baltimore Arbutus 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5520 Carville Avenue Funeral 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 ☐ Never Married 2 🛮 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural" Specify: white 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Factory Worker 12 0 Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Steven Norris Carrie Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas R. Wright / Husband 5520 Carville Ave, Baltimore MD 21227 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)
Cedar Hill Cemetery 1/6/2010 BAltimore MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Victor P. Doda, Jr 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Home, Inc Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ brain DOXIC MIUTE disease or condition days Medical resulting in death) Due to (mas a consequence of): Examiner orohary 1ears disease Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit ongestive ear Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown hronic obstrictive bulmonan disease Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autonsv 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) RESOOI 2010 anuan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Hanvver Hospidal Daltimore 0 CIQV 19

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN 05

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 07 2010 ear 1:20 P M LILLIAN ZABA Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE PIKESVILLE ENVOY OF PIKESVILLE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X**(X) F Months Days Hours 10/20/1922 87 219-16-9657 MD Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes aXX No or 28a-f BALTIMORE BALTIMORE MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a Funeral USA 21208 3305 TIMBERFIELD LANE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. "natural", or ğ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည YETTA MORRIS ZUSKIN ZUSKIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REISTERSTOWN, MD 21136 312 HIGH KNOB LANE, SANDY GOLDBERG/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/10/2010 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Alzheimers disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) g physician and as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tyes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 2 No 1 🗆 Yes ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) (Stac Jan, 7, 20/0 0061199

Registrar

State

Jason

Black

4108, Towson MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician/ PALACIOS Dav RIE Month Year 5:05 PM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death -60 R HOSPI. IMORE BALT | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, Year | 0 5 / 0 5 / 1944 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗹 F Yrs Director 219-40-7284 Tennessee Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗹 No <u>Anne Arund</u>el Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 694 205th Street 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i mayinjury or other traumatic event, the Medical Examinane. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 

✓ Widowed 4 

☐ Divorced Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Westinghouse/ College (1-4 or 5+) Maintenance Technician Northrup Grumman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bonnie Marie Adams Edward Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 843 Clarke Bouleward, Baltimore, MD 21227 <u>Ray Palacios / Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Pk 01/06/10 |Baltimore, MD 21. Signature of Janeral Service Licenses 22. Name and Address of Facility G, J, Gonce Funeral Home, Riviera Drive, Pasadena, MD 21122 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pnysician/ JUNG. METASTATIC disease or condition Medical resulting in death) Examiner EU MON Sequentially list conditions, if any, Lading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of, physician and the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes 2 VZ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Definition in the least of my showledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) RECOUD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REBECC -1GH 0 3001 SOUTH HANOVER STREET BALTIMOREMD 21225 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 12, 2010 Indiana Pereira 8:45 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🎇 F Hours Months (Month, Day, Year) une 5, 1938 Director 219-98-3544 71 June Nicaragua Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director Maryland Montgomery 1 🗌 Yes 2 🗓 No Bethesda 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5612 Jordan Road 20816 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force 1 ☐ Yes 2 🛣 No If Yes, Give Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Nicaraguan 3 Midowed 4 ☐ Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Narciso Lacayo Maria De Bavle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Luis G. Pereira / Son 1315 Foxwood Drive, Midland, Michigan 48642 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 
Burial 2 
Cremation 3 
Removal from State cemetery, crematory or other place) January 13 Montgomery Crematorium, Inc 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 2010 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Signature of Funeral Service License Mackette Empus M01305 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Ovarian Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events burial-transi physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy certificate 1 Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other:  $_4$   $\square$  Nursing Home  $_5$   $\square$  Residence  $_6$   $\square$  Other (Specify)  $\square$  Hospice 2 🗶 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 5 Pending Accident Investigation after death Director: / Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. within 24 hours a Medica Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Koucetchou, mi) 29c. License number 29d. Date signed (Month, Day, Year) 163747 January 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Jocelyne Kouatchou, MD

31. Date filed (Month, Day, Year,

JAN 1 4 2010

32. Registraris Signature

6001 Muncaster Mill Road, Rockville, Maryland 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY <u>2</u>010 11:22A M PAUL DORIS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 8. Date of Birth **Funeral** Months Days Hours Min. 1478/1925 84 Yrs. Director 219-18-3872 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 💢 No MD **HARFORD** BEL AIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 555 S. ATWOOD ROAD, #305 21014 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married <u>۾</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: WHITE Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SALESPERSON CLOTHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PAULINE MORRIS CHERNOCK GLAZER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 FULFORD AVENUE, BEL AIR, MD 21014 GINA SCHAEFFER / ATTORNEY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State BNAI ISRAEL CONG. 1/13/2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause in each line. wing, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) your Medical as a consequence of Examiner Sequentially list conditions. Examiner If any, leading to immediate Due to (or as a consequence of) Cause (Disease or iinjury ysician and ne burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 phy: the Hospital or Attending Physician: The law requires that the death certificate attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death m 80051736 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 9 Unknown significant onditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 this certificate 2 No Yes 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Daris Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 KER/Outpatient 3 IDOA funeral 27. Manner of Death Certificate: 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Sul Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Jurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title 07 on who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month ANU Pay Y 9 Year 21 3:55FM Ζi Medical 4b. City, Town, or Location of Death 4c. County of Death 1 t i more 4a. Facility Name (if not institution, give street and number)
Saint Joseph Medical Examiner Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Country) Director Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Ges 2 No 10e. Street and Numbe 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Specify. Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life\_DO NOT use retired) College (1-4 or 5+) Harbor Be 17. Father's Name (First, Middle, Last) 2 and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code Important: If item any injury or other Method of Disposition Place of Disposition (Name of 20c. Location - City or Town, State Page 1 permit. Page 1 a Department of F 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Se no, 2 Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MYOCARDITIS SECONDARY TO HIV disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ARRHYTHMIA SECONDARY TO HIV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year signed by the a ld be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has autopsy performed completed filled in by the funeral director, page 2 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 7. Manner of Death 28b. Time of Certificate: 28c. Injury at To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) morn D18406 2-10 Uman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON. MARYLAND FRANCIS M. D. 7601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 1/2001 OCMF 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** PM Dolores Ratcliffe 2010 lanuar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Square 6. Si Center Kosedak Franklin Hospita Himore 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign Country) Ireland Northern Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😾 F Months Days Hours Min. 220-80-2956 68 **Director** Feb. 2, 1941 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ortant; If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, It a Madical Examinat must be notified at 10d. Inside City Limits MD Baltimore Director Essex 1 ☐Yes 3√☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 56 Yew Road 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or ite 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: ۾ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Sheppard Margaret McCurdy ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Francis Ratcliffe /husband 56 Yew Road Baltimore MD 21221 Important: If item any injury or othe 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Bayview Crematory 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 1/12/10 Baltimore MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 MAce AVe. Balto. MD Connelly Funeral Home of Essex 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performed? Yes 2 No certificate 2 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral ( 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐No 2 Accident 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide lical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. illed in by the f within 24 hours a

the Maryland

death with

Maryland 21215-0036

Baltimore,

Pages 1 and 2 should

permit.

30. Name and address of person (who completed cause of death (tron 23a) (Type, Print)

manner stated

29d. Date signed (Month, Day, Year)

Martin J. Sheridan M.D. 9000 Franklin Square Drive Baltimore, MD 21237 31. Date filed (Month, Day,

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day \ 0 Month Alvina Roper 8:45 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town or Location of Death Examiner 4c. County of Death Baltimore Union Memorial Hospital Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday **Funeral** Days Feb. 26 Months Hours 1 M 2 12 Director 212-28-3061 MĎ Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director Baltimore MD Essex 1 Yes 2x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21221 32 Berkshire Road "natural", or items edical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or Yes 2 No Yes, Give 1 ☐ Yes 2 🙀 No Specify: Specify: White Completed 3 ₩ Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Emma Jane Carter မ George William McElwee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Ann Chaillou /daughter 32 Berkshire Road Balto. MD 21221 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, Oak Lawn Cemetery 1 Burial 2 Cremation 3 Removal from State Baltimore MD 1/14/10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Mace Home Ave Balto MD of Essex 21221 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death A cute Commony Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** 10 onenery artin Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine MS My per tension nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical e attending p d for use as t 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? this certificate 2 🗌 No 1 Tes funeral director, 25. Was case referred to medical Medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺ No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred hours after death. 5 Pending 1 Natural 1 🗌 Yes 2 🗌 No Accident Investigation completed filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

Union

30. Name, and address of person who completed cause of death (Item 23a) (Type, Print)

Yours

31. Date filed (Month, Day, Year)

Deanna Mae Red		State of Maryland A I-For State Registrar	Departmer // Certificate			d Mental H		Reg. No.	2010	00485		
Physicia	n/	Decedent's Name (First, Middle,Last)	Year	3. Time of Death								
Medical Examir	ner	Deanna Mae Recher  4a. Facility Name (if not institution, give street and number)		41	o. City, Town, or I	ocation of Deatl	January		10 : County of Death	0923 hrs		
,		7509 Ritchie Hwy #6		Anne Arundel								
Funeral		22/ 10 060/	e (In yrs. last birthda	ay)	If Under 1 Year Months Days	If Under 24Hrs Hours Min	_		DD/YYYY) 9. Bir Foreig	an <b>West</b>		
Director		Usual Residence of Decedent	44	Yrs.			Sept.	. 4,1965 Country Virginia				
any	Ì		10c. City, Town or							10d. Inside City Limits		
Maryland 28a-f show	ě	Maryland Anne Arundel	Glen Bu	rni						1 Yes 2 X No		
or 28a-	Director	10e. Street and Number 7509 Ritchie Highway, Unit	6		10f. Zip Code <b>21061</b>			-	zen of What Cour	-		
death with the Maryland or items 23a or 28a-f sho	필	11. Marital Status 12. Was Decedent	Ever in U.S. 13		Decedent of Hisp	panic Origin? ( S	pecify Yes or N		14. Race - Ameri	ican Indian, Black,		
r death	Funeral		X No		s, specify Cuban,		Rican, etc.)	White				
urs afte: ural",	ᇫ	3 Widowed 4 Niporced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade com			Yes 2 X No	work done	Specify:  16b. Kind of Business/Industry					
5 72 hou m "nat	leted	Elementary/Secondary (0-12) College (1-4 or 5	5+) duri		st of working life					duator		
003 within giene. her tha	Comple	12 17. Father's Name (First, Middle, Last)	Wa	ILLL		8.Mother's Name	/Eirst Middle		Food Ind	ustry		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Be C	Sherman Edward Knox					iss Gi		,			
D 21 should ! and Mer 7 is mar		19a. Informant's Name/Relationship (Type, Print)							ty or Town, State			
and 2 stealth a	ŀ	James Gregg Chafin, Jr./So 20a. Method of Disposition	20b. Place of D	Dispositi	on (Name of cem				Location - City or	and 21146 Town, State		
MOFe, Pages 1 an nent of He ant: If ite		1 Burial 2 X Cremation 3 Removal from Sta 4 Donation 5 Other Specify:	metro (	_			n. 13, 010	Ba	ltimore,	Maryland		
Baltir permit. P Departme Importar injury or	1	21. Signature Furleral Service Licensee				of FacilityCre	mation			Maryland,Inc. nd 21228		
	-	A1:	1							Approximate Interval		
Physician Medical	-	failure. List only one cause on each line.	intoxicat				, ,			Between Onset and Death		
Examiner	-	or condition resulting in death)  Due to (or as a conse		201								
	اقِ	Sequentially list conditions, if any, leading to immediate Due to (or as a conse	quence of):									
4.	Examiner	cause. Enter Underlying Cause (Discass or injury that initiated events resulting in death) Last  Due to (or as a conse	quence of):									
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	edical	X UNPENDED AMENDED 23a,2	7,28a-f,	peri	nE, g900	2/24/10	TT C	Tan				
3876 rtificat fing phy as the		IF FEMALE:  3b. Was decedent pregnant in the past 12 months?  23c. If yes, outcom	e of pregnancy	Feta	Ideath 3	Ectopic pregna	ancy		<ul> <li>Date of delivery</li> <li>Month D</li> </ul>	/ Day Year		
Box 6876 e death certificate the attending phy ed for use as the i	sici	1 Yes 2 No 9 ✓ Unknown 9 Unknown	time of death 5	Othe	er (Specify)			1				
ords, P.O. Box 6876  w requires that the death certificate sbeen signed by the attending phy should be detached for use as the l		Part II. Other significant conditions contributing to death	but not resulting in	the un	derlying cause gi	ven in Part I.	23e, Did	tobacco u	use contribute to	the cause of death?		
S, P.	ed by									pably 4 V Unknown		
Cord	Completed						24a. Was			topsy findings available completion of cause of		
tal Rectinan: The l		25 Was case referred to medical			26 Diago	of Death (Check	1 Yes			es 2 No		
Vital   ysician: his certifi director,	o Be	examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatier	nt 2 ER/Outpa	atient	-	Other Nursin		Resider	nce 6 🗸 Other	Scene		
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the restire death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	⊢†	27. Manner of Death 28a. Date of Injur (Month, Day,Ye	y 28b. Time	e of Inju	·	at Work?	28d. Describe	how inju	ry occurred			
IVISIOF or Attend after death. Director:	läi	2 Accident Pending Fd 1/11/	/10 Fd 9 sury - At home, farm,		amı	es 2X No	unk	(Street or	ad Number or Bu	ral Poute Number City		
Divisior ospital or Attend hours after death neral Director: y filled in by the	Certification:	Suicide 6 A Could not be determined (Specify)		509 Rito	ral Route Number, City Chie HWy							
		29a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of exam				e and place, and	due to the cau	ise(s) and	d manner as state			
To the within 2 To the complet	8	and manner stated.  29b. Signature and title of certifier			29c. License				Date signed (Mor			
		That we kind ?	78	$\lambda$	O.C.M	I.E. OCME		Janu	uary 12, 2010	)		
d	t	30. Name and address of person who completed cause of de		<del>U i</del>	11 Page Sta	at Daltimas	MD 2422	1				
₩ Sta	te	Theodore M. King, Jr., MD. Assistant Me  31. Date filed (Month, Day, Year) 32. Registrar	edical Examine	a 1	11 Penn Stre	et, baitimore	=, IVIL) Z I ZU	1				
Registi	-	JAN 1 4 2010 Sema	1 par	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. / Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:59 AM Month Janle. Medical Name (if not institution, give street and number Examiner Town, or Location of Death 4c. County of Death Avenue HIMOVE. If Under If Under 24 Hrs. Funeral 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F 89 Min. Country) 02/11/1921 Director ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City Town or Location

RuHIMOre 10b. County 10d. Inside City Limits **Funeral Director** 1 Yes 2 🗆 No 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or Yes 2 No Yes, Give Completed by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life\_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be ၉ e 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of City or Town, State crematory Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of unera 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ unc disease or condition O or Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner ii any, leading to immediate cause. Enter Underlying Due to (or as a consequence or To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death this certificate has been signed by the rail director, page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Die topacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No Yes 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita Other: ၉ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of D atl Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by Homicide determined within 24 hours an To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 00055059 of person who completed cause of death (Item 23a) (Type, Print) 3333 N Calvert St Suit 575 Balto MD 2218 MD

DHMH 17 Rev 7/2009

State Registrar

2

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#2perDVR, G899, 1/14/2010, WS
State of Maryland / Department of Health and Mental Hygiene
amend items 23b, 24a per doc g899 1-19-10 vt

Certificate of Death

Reg. No. O. C. J. O. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 Physician/ Month Jan Vivian В. Sobieski 13 7:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Riverview Nursing Center Baltimore Essex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) OCCUTH, 733 Year 926 1 M 2 STF Months Days Hours Min. 215-20-7818 83 Director WVA Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City. Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore Essex 1 🗌 Yes 2 😾 No 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1 Eastern Blvd. 21221 USA or items within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Force ģ 1 Never Married 2 Married ☐ Yes 2 ☐ XNo Baltimore, Maryland 21215-0036 permit, Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan any injury or 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechandiser J.C. Murphy 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leo H. Burke Anna Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Besche /daughter 317 Suffolf Road Balto. MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Holly Redeemer 1/16/10 Baltimore MD4 Donation 5 Other (Specify) e f Funeral Service License 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, exemplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death -Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and the burial-tran resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year this certificate has been signed by the ral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Certificate: To 1 🗀 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) uneral Director: Affer the dilled in by the fermion of the dilled in by the fermion of the fermi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1- Natural 5 Pending 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier DO. 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1124 Mace Ba Honore 31. Date filed (*Month, Day, Year*) **JAN 1 4 2010** State Registrar

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			For State Registrar		a. , .a.		rtificate			a montan	Reg. No.					
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	Funeral Director		5. Social Security Number		e (In yrs. la	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 F	1rs. 8. Date of in. 12 1	Birth <i>Day, Year</i>	3.		rthplace (State or Foreign ountry)		
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Baltimore, Maryland 21215-0036	urs afte :ural", al Exar	ted k	X□ Widowed 4 □ Divorced			1 ☐ Yes 2	X∏ No	Specify:		Specify: Black						
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and	ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, Kenneth C. Si	,						Name (First, Midd en Day	lle, Maide	n Surname,	ne)			
ary	nould bund Me s mark umatic		19a. Informant's Name/Relations			19b. Mailir	na Address	(Street a		<u>-</u>	ber City	or Town St	ate Zin C	odel		
Σ̈́	nd 2 sh ealth a m 27 is ier tra		19a. Informant's Name/Relationship (Type, Print)  Kimberly Green-Daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 3805 West Garrison Ave, Baltim													
ore	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		20a. Method of Disposition 1X Burial 2 ☐ Cremation	3 ☐ Removal from State	C	lace of Dispo emetery, cren	natory or ot	her plac		Date		Location -	City or Tov	wn, State		
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	s executed sian and urial-transit	ᡖ	that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):		-								
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Box 68760	ath certificate be attending physic for use as the bu	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live Birth			] Estania n	roonana				23d. Date	ate of delivery			
ĝ	requires that the death certificate be been signed by the attending physici should be detached for use as the bu	Completed by Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant a			Other (spe		у		-	Mon	nth I	Day Ye	ear	
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ds,	requires that the de been signed by the should be detached	ted b	CONGESTI	YE HEAD	27	FAIL	- U R	Ē		_ 1 [	☐ Yes	2 □ No	3 🗌 Prob	ably 4 🛂 🛈	nknown	
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VIII ∶	nysicia iis cert direct	To Be	examiner? 1  Yes 2  16	Hospital:	ent 2 🗆	ER/Outpatien	it 3 □ DO	Othe	r	g Home 5 ☐ Re	sidence	6 ☐ Other	(Specify)			
ָ סַ	After th		27. Manner of Death 1 Natural 5 □ Pendir	28a. Date of inju (Month, Day	ry r, Year)	28b. Time of injury	- 1	c. Injury work	at ?	28d. Describ						
DIVISION	Attender death sector: yether on the	Certificate:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of Inju	ry - At ho	me, farm, stre	M eet, factory,		Yes 2 No	28f, Location	(Street a	nd Number	or Rural F	Route Numbe	r.	
<u> </u>	Ital or Ins afte ral Dire	al Ce		building, etc						City or T	own, Stat	te)				
: /	to the nospital of Attending Priysician; the law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	Medical	(Check 2 Medical E	Physician: To the best of examiner: On the basis of examiner: To the	camination	and/or invest	igation, in m	opinia v	n, death occurre	ed at the time date	e and plac	e and due	to the caus	se(s) and man	ner stated.	
	vithin To the comp	≥	29b. Signature and title of certifier	Nuise Plactioner. To the	/ Jest of Thy	Knowledge, d	29c.	License	number	place, and due to	29d. D	ate signed	(Month, D			
			Marles	1 Svert	ino		1	10	020	390	20	N	7, 6	2010		
			30. Name and address of person	who completed cause of de	eath (Item	23a) (Type, P	rint)	KI.	wo . Ros	m inn	7.1	218				
	Stat		29b. Signature and title of certifier  30. Name and address of person  Clivolocs / for  31. Date flag (19th Payler)	32. Registra	Signa	arkel	9,	/4	DI	70.0.0		-10				
	Registra	r	COOL FAID	/	1											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#30perDVR G899 of 4141 (2010 Wental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** Stokes Μ. Georgia 01 09 2010 5:05p.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elery Manor Assisted Living Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🙀 F Months Days Hours Min Director 217-22-4332 19 VA 10 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10h Counts 10c. City. Town or Location Director 1 □Yes 2√ No Pikesville Baltimore MD 10e. Street and Number 10g. Citizen of What Country? Funeral 37 Tentmill Lnae 21208 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ģ Specify: 3X Widowed 4 □ Divorced Black Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Stewart Dept. College (1-4or 5+) Elementary/Secondary (0-12) Supervisor Store 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eliza Davis ပ George Meacham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tentmill Lane, Pikesville, Md 21208 Lee M. Stokes-Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages Department of Important: If it any injury or o Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 1/20/10 Owings Mills, 22. Name and Address of Eacility
March F/H West 21. Signature of Funeral Service Licensee d 21215 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due as a consequence of): Examiner Sequentially list conditions, if any leading to immunity cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physiclan: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760. physician . Pe IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 ☐ Probably 1 ☐ Yes 2 ☐ No nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 1 Yes the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Medical Certification: To Other: 4 Nursing Home 5 Residence 6 Wher (Specify 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Park Heights Ave. Baltimore, MD 21215 Howard Cohen 6717 32. Regis 's Sig State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20b per Fh g900 2/2/10 TT
State of Maryland / Department of Health and Mental Hygiene

			For State		State of M	aryland	-	rtment of He		Mental Hy	/giene	€			
			Registrar  1. Decedent's Name (	Firet Middle I as	t)		Cer	tificate of De	eath	To But is to	Reg. No. 2 3 Time of Death				
	Physicia		Delores	i iist, iviidale, Las	Evel	vn		Smith		Month	eatn 1 <b>2</b>	2010	3. Time of Death		
100	Medic Examir		4a. Facility Name (if no	ot institution, give		<u>, , , , , , , , , , , , , , , , , , , </u>		4b. City, Town, or L		01 12 201 4c. County of E					
			Gilchris	t Hospi	ce				son				imore		
	Funeral		5. Social Security Num		7. Ag	e (In yrs. las		If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth av. Year)		hplace (State or Foreign		
	Director	Usual Residence of Decedent					Yrs.			07 1	9	39	MD		
	and show	5		0b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits		
	Maryla 28a-f stifiec	rect	MD	NA			Balt	imore					1X Yes 2 No		
	a or 2	Funeral Director	10e. Street and Numb	er				10f. Zip Code			10g. C	10g. Citizen of What Country?			
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	r deal or iter niner		<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li></ul>	1 2 V Marriad	12. Was Decedent 8 Armed Forces?		13. W	las Decedent of Hisp Yes, specify Cuban,	panic Origin? (Sp Mexican, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Amer Black, White			
5-0036	s afte ral", c Exarr	Completed by	3 Widowed 4		If Van Ohio A		1 ☐ Yes 2 No Specify:					Specify: B	lack		
2-0	hour natur dical	Set	(Specif	15. Decedent's Ed fy only highest gra	lucation	Ţ	16a. Deced	ent's Usual Occupat	ion	16b. h	16b. Kind of Business Industry				
21	nin 72 ne. <b>:han</b> " <b>e Me</b>	mo Tuo	Elementary/Secon	day (0-12)	College (1-4 or 5	ō+)	life. DC	ind of work done du NOT use retired)	_	Ε.	,				
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Ž	iould Ind Me		19a. Informant's Nam		pe, Print)		19b Mailin	g Address (Street and			ar City o	r Town State Zin	Code		
	d 2 shalth a alth a 27 is		Kenneth	Smith-	Husband								Md 21215		
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Ĕ	ment cannot tant: It inny or		4 Donation 5	Cremation 3 ☐  Other (Specify	Removal from State	1	-	n Forest	Vet 1	$\frac{29}{20}/10$	Ow	ings Mi	ills, Md		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fune	ral Service Licens	i. Jan	,,)	Ma	Name and Address Arch F/H 300 Waba	of Eacility West						
23a. Part 1. Enter the disease, or complications to traused the dear												Ley_na	Approximate		
	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition												Interval Between Onset and Death		
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8760	ificate	Med	IF FEMALE;												
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alF	sician: The la certificate ha irector, page 2	BeC	25. Was case referred examiner?	to medical				26. Place	e of Death (Chec		2 <b>X</b> N	o 1 Yes	2 No		
Ζit	Physician: this certific al director,	일	1 ☐ Yes 2 🔀 1	Vo I			R/Outpatient	3 DOA Other;	4 Nursing H	ome 5 🗆 Resi	dence 6	Other (Specia	6) Hospice		
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7	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	29a. Certifier (Check only one) a 3 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 3 Certifying Nurse Practioner:										, and due to the ca	ause(s) and manner stated.		
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			hijan	i Sut	CRNP			RIUA	194		Jan	May D,	2010		
			30. Name and address	of person who co		eath (Item 2	3a) (Type, Pr								
			Marian				narlis	St. Tou	USON,	AND.	210	204			
	Stat Registra	_	31. Date filed (Month, I	vay, rear)	32. Registra	ar's Signatui	e	•							

DHMH 17 Rev 7/2009

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ILDRED STURM 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Carroll Carroll County General Westminster Birthplace (State or Foreign Country) PA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Month, Day, Year) 04-03-1923 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours Min 1 ☐ M 2 🔯 F 86 179-16-8772 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21786 7200 Third Ave Apt u203 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No If Yes, Give Year or Dates: Specify. Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Education Data Collector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Foltz Alphonse Freeman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Luthersville, MD 21093 1612 Barthel Rd Charles Sturm (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 01-15-2010 Hickory, MD St. Ignatius Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): neumonia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 No 1 □ Yes 2 No 1∏Yes 26. Place of Death (Check only one) Hospital: Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending

Examiner The law requires that the death certificate be executed physician and the burial-transit Box 68760, Physician/Medical attending p signed by the a Division of Vital Records, P.O. \$ After this certificate has been s funeral director, page 2 should Completed Be Certification: To al or Attending P s after death. I Director: After t filled in by the

**Physician** 

/Medical

**Examiner** 

Director

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Completed

Be

MD

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Modical Experiment by mutilified at once.

Physician

/Medical

**Examiner** 

Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner? 1 Yes 2 No 1 Natural

27. Manner of Death 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

29a. Certifier 1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 2010

Reisterstown, MD

State Registrar

Vento M.P. 114 thomas 31. Date filed (Month, Day, Year) 32. Registrar's Signature 4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24 hours a

To the Funeral C

completely filled Hospital

Medical

			1 - State Registrar	State of Marylan	d / Depa		lealth and I	Mental Hygi	g. No. U	0 0 1 4 9 2				
۸.	Physici		1. Decedent's Name (First, Middle, Last)  Althea Sigethy					Month January	13 20°	ar				
7	/Medic Examin		4a. Facility Name (If not institution, give stre	eet and number)		4b. City, Town, or	Location of Death		4c. County of Death					
	× ×		Tate Hospice House			Linthicu			Anne Ar					
	Funeral Director		5. Social Security Number  228-14-7703  Usual Residence of Decedent	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 26	, 1917 M	Birthplace (State or Foreign Country) assachusetts				
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	be filed within 72 hours after death with the Maryland at Hygiene. A person of other than "natural", or Itams 23a or 28a-f show dother than "natural", or Itams 23a or 28a-f show avent, I a Mudical Eratti na must be notified at	ctor	Maryland Anne Arund	e1	Lint	thicum 1□Yes 2页								
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	s 23e	erai	703 E. Maple Road	Was Decedent Ever in U.	C 12 V	2109			nited States  14. Race - American Indian,					
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ž	ral', o	by	3 ₩ Widowed 4 Divorced	tf Yes, Give Year or Dates:	1	☐ Yes 21√2 No	Specify:		Specify: White					
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2	within 72 ene. than "nat	duc	Elementary/Secondary (0-12)	College (1-4or 5+)		maker	)		Own Home					
Maryland 21215-0036	i Hygid other	Be Co	17. Father's Name (First, Middle, Last)		поис	MARCE	18. Mother's Nar	ne (First, Middle, M	aiden Sumame)					
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Tan Tan	2 sh and is m	. Vi	19a. Informant's Name/Relationship (Type	, Print)				ıral Route Number,						
	1 and Health In 27 Ther tr		Mary Bruwer/ Daugh 20a, Method of Disposition			. Maple F sition (Name of		nthicum, I	Maryland Oc. Location - City					
0	Pages nent of I int: If Ita		1 ☐ Burial 2 ☑ Cremation 3 ☐ Ren  '4 ☐ Donation 5 ☐ Other (Specify)	noval from State	emetery, cren	natory or other plac		iry 14,						
Baltimore,			21. Signature of Funeral Service Licensee			matory, ] . Name and Addres				, Maryland f Maryland, In				
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/og/	Physician pe executed /Medical Examiner	ical Examiner												
O. BOX 68	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	If yes, outcome of pregna. 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year					
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n ot vig	Hospital or Attending Physicien: The Attending Physicien: The Attendent Perder death Funeral Director: After this centricate toly filled in by the funeral director, pag	on: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hos  7. Manger of Death  1 Natural 5 Pending	pital: 1  Inpatient 2  1 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury	er: 4 ☐ Nursing H	ath (Check only one lome 5 \( \) Reside 28d. Describe ho	nce 6 ther (	Specify.Hospice				
DIVISION OF	or Attending Pater death. I Diractor: After I	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre		Yes 2 □No	28f. Location (Str City or Town,	treet and Number or Rural Route Number, n. State)					
	To the Hospital of within 24 hours af To the Funeral D of mpletely filled in	edical C	29a. Certifier 1 Certifying Physic (Check only one)	ian: To the best of my known: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the timestigation, in my op	ne, date and place pinion, death occu	, and due to the ca irred at the time, da	use(s) and manne te and place, and	er as stated. due to the cause(s)				
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			Conna m o	render mb		DO	05473	3.4	01(1	3/2010				
	3		30. Name and address of person who comp	oleted cause of death (Item	23a) (Type, I	Print)	124	C/-7	0.5.150	/m 3 - 7 1				
	-01		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture#	WOOD N	a Diede	4 over 1	une,	11D-440(-1				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 9:05 Renford Smith, Sr. AN 2010 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Agnes Baltimore Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Sex 1X M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 233-44-2434 79 April 19,1930 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2040 Griffis Avenue 21230 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 🛣No Specify. Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Local 101 Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Smith Maggie Whitaker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma F. Smith (Wife) 2040 Griffis Avenue Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Cremation 1/11/10 Glen Burnie, Maryland 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A. 21. Signature of Funeral Service Licensee <u>3204 Mountain Road Pasadena, Maryland 21122</u> 23a. Para. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION LOUR Due to (or as a consequence of): CORONARY ARTERY DISEASE 10 years Sequentially list conditions, if any, leading to minieulate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy perform 1 □ Yes 2 No FIBRILLATION 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 € DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner** Examine

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau

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/Medical

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Baltimore, Maryland 21215-0036

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physician and s the burial-trans nse atter for u been signed by the should be detached cate has page 2 s certificate

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Physician/Medical þ Completed director, Be Certification: To funeral within 24 hours after death

To the Funeral Director:
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CHRONIC OBSTRUCTIVE AIRMY "ISOME

ORAL/PHARYNGEAL CARCINOMA ATRIAL

27. Manner of Death Natural 2 Accident 3 ☐ Suicide

6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 14 2010

(Check only one)

29c. License number D22644 29d. Date signed (Month, Day, Year) JANUARY 9,2010

J Duig Clerno 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jerone Snyder

900 South CATON Avenue Baltimore Maryland

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last, 2. Date of Death Day Month **Physician** noma /Medical januar 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner altimore Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F 36 Yrs. Months Days Hours Min Director 10/10/1973 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, trachedical Evandam instruction to inclined at 1 Nes 2 No Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within Elementary/Secondary (0-12) College (1-4or 5+) 12 Johns th and Mental Hygier 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is n any Injury or other traur Stone Warm Columbia MD 21045 6071 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State axtana 12010 4 □ Donation 5 □ Other (Specify) Eignature o Funeral Service La nsee Name and Address of Facility Horne Guilford 23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death lentrice las Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-tran and resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial be Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy

Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a Mes 2 □ No o. 20 2009 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 2 No 1 ☐ Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral I 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Injury at Work? 28d. Describe how injury occurred Division or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

Fisher

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2010

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month January 8, 2010 Medical Examiner Pamela Gail Turpin 1631 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c County of Death 1208 Bridge Crossing Apt. 1 FSSAY **Baltimore County** 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months Days Hours Min. Director 214-84-3412 Nov.20,1964 1 M 2X F Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Essex 28a-f show 1 Yes 2 X No traumatic event, the Medical Examiner must be notified at once. 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1737 Eastern Ave, 這 21221 USA items 23a 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces 1 Never Married 2 Married White etc. 2X No Yes White 3 Widowed 4 Divorced If Yes, Give Year Yes 2 No specify Specify: "natural", <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filled within 72 hou
Department of Health and Mental Hygiene.
Important: If ifen 27 is marked other than "nat
injury or other traumatic event, the Medical East during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker own home 12th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Broderick Turpin Agnes G. Ferrell 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Wadkins /sister 1605 HomeySuckle Ridge Court Annapolis MD 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 1/14/10 Baltimore M D 4 Donation 5 Other Specify 21. Signature of Funeral Service Licens 22. Name and Address of Facility 2 Name and Address of Facility 300 Mace Ave Baltimore MD Connelly Funeral Home of Essex 21221 Part I. Enter the disease. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and Medical Atherosclerotic cardiovascular disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical attending physician or use as the burial -**X** UNPENDED **AMENDED** 23a,27,perm,E g900 2/19/10 TT Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death Ectopic pregnancy Month Day Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✓ Unknown 9 Unknown the Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performe death? page Yes 2 V No Division of Vital 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 🗸 Other: Scene 2 ER/Outpatient 3 DOA this 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural To the Funeral Director: 24 hours after death. 5 Pending 1 Yes 2 No 2 \_\_ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E January 9, 2010 alliante 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31 Date filed (Month, Day, Year) 2. Registrar's Sign State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ン分い GeR RMAN 6:05 AM 1601 2010 Medical 4a Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death A V Salt MURE MediCAL La Saltimore Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Funeral 1 XM 2 □ F Country) Maryland Director 954 217-58-6191 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Examiner must be notified at any injuy or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 No Md. Baltimore Whiteford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4037 Prospect Road 21160 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 Married TX□ Yes If Yes, Give 2 🗆 N Baltimore, Maryland 21215-0036 1970-1974 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 👽 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Concrete Company Dispatcher Be 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Miller 17. Father's Name (First, Middle, Last) William Testerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. 4 Hydroplane Drive Middle River, Md. 21220 Stefanie Simpson 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 4 Donation 5 Other (Specify) 1-16-2010 Balto. Md. Bayview 21. Signature of Funeral Service Licensee Schimunek FUneral Home 22. Name and Address of Facility 9705 Belair Rd. Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line TNEUMONIO Immediate Cause (Final iRation Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant 9 Unknown Pregnant at time of death Other (specify) 1 L Yes 2 L 9 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed phods 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an performed' After this certificate 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 WNo 1 Tes ဂ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director: Af Accident Investigation Suicide Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) San MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 NORTH GREENE STREET BALT, MURO, MD 21201 Pan Muel C Mi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 2010 Registrar

			For Stete Registrer	State of M		partment of ertificate of		and Mental H	ygiene Reg. No.		004	97		
	Physic	20	1. Decedent's Name (First, Middle, Last)					2. Date of D	eath Day	Yeer	3. Time of	Death		
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	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location					10d. Inside Ci	ity Limits		
	Maryla	tor										1 X Yes 2 □ No		
	th the	irec	10e. Street and Number			10f. Zip Cod	е		10g. Citi:	zen of What Cou	intry?			
	23a unit	rai	622 Still Creek L	ane		20	878		Uni	ted Sta	tes			
36	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural", or itama 23a or 28a-1 show evant, tre Medical Exerciter must be invitited at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates:	t Ever in U.S. 1 ?  No	3. Was Decedent of If Yes, specify C		igin? (Specify Yes or N n, Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White				
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Ma	d 2 s th an t7 is i		Anne Thrush / Wife					ne, Gaithe				1878		
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Baltimore,	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service License	2 wit	M01305	Robert A. P	dress of Facility Umphrey nteomery	Funeral Home/ Avenue, Rock	Rockvi	ille, Inc.	1 20850-	2805		
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8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	s a consequence of):									
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/ita	Phyaician: this certifica al director, p	Be (	25. Was case referred to medical examiner?					of Death (Check only						
of \	Phyai this o	ပို	I ⊔ tes 2 🔼 No	ospital: 1 Inpati	and the second second			rsing Home 5 KRe			ity)			
		ion	27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury 28b. Time ay Year) Injur	y \	njury at Vork? Yes 2	28d. Describe	how injury	occurred				
Division	art sat	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28f. Location	(Street and own, State)	d Number or Rui	ral Route Num	ber,						
	To the Hospital or Atti within 24 hours after de To tha Funaral Diracti completely filled in by ti	edical Ce	29a. Certifier 1 Certifying Phys	sicien: To the best ner: On the basis of and manner s	of examination and/or	eath occurred at the investigation, in m	e time, date an ny opinion, dea	d place, and due to the	e cause(s) e, date and	and manner as place, and due	stated, to the cause(s	;)		
	To th within To th	Me	29b. Signature and title of certifier	11		29c. Lic	ense number		29d. Date	e signed (Month	Day, Year)			
			* Mchlan	eV		D6	7258		Janu	uary 11,	2010			
			30. Name and address of person who co				n Dada	Doole	o M-	I J	20050			
	Sta	te	Nicholas J. Farre 3 31. Date filed (Month, Day, Year) = -		rar's Signature	ar center	r Drive	, Rockvill	e, ma	тутапо	20030			
	Registi	-	14 1 4 2010	Anda	A. Be	Plant.								

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** LOID /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KESS 919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** -50-8165 1 □ M 2 F Director Usual Residence of Decedent death with the Maryland 10a State ral', or items 23a or 28a-f show Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits m 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? X1015 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify: Specify: WHITE ò 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) a marked other than Elementary/Secondary (0-12) College (#1-4or 5+) Hygiene. COUNT EACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Michael Petkash Pages 1 and 2 should nent of Health and Men Marjorie Steir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Versperman (Husband) 1919 Cypress Drive Bel Air, MD 21015 Itam 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 01-12-2010 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each ne. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medlcal the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 XNO 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an director, page 2 autopsy performed?

1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No Hospital: Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Natural 5 Pending 1 □ Yes 2 □ No 2 Accident investigation Director: 3 🗀 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi D0058475 NEVATPUNEN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 62. Registrar's Signature ID NOWYDL ADIZUPHIA READ BIZLAZIZ, MOZLOTY State Registrar Barks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 01,99 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician/ Month 1829 PM Janette Christine 2010 Waugh anuar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai HOSPITAL OF Baltimore Boltimore citu N/AIf Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth g, Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 - M 2 -Days Hours 0472571966 Maryland 43 Director 218-78-2181 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director iral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No Randallstown Baltimore Co 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9712 Liberty Road 21133 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: "natural", 3 Widowed 4 Divorced Completed Black event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) Grade Self Employed Cosmetologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Warren Wauqh Mamie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. Doris Barnes(Step-mother) 1901 Elgin Ave. Apt 106, Balto., MD 21217 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other King Memorial Cemetery 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/16/10 Baltimore, MD 22. Name and Address of Facility
JOSeph H. Brown Jr. Funeral
2140 N. Fulton Ave., Balto., 21. Signature of Funeral Service Licensee Home 21217 anich 1. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Multiossan day disease or condition Medical resulting in death) Due to (or as a co equence f): Examiner shack Septic Sequentially list conditions, Physician/Medical Examiner Due to or as a consequence of If any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Day 2 No Ves ed by the a 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ vasculitis 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? myelitis 24a. Was an Transverse performed? Yes 2 No 1 Yes 2 No filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The continuity is a continuity of the control of th only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) MBBS RES-000 January 08 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI HOSPITAL OF BALTIMORE KOSAS-CALDERON MBBS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar
DHMH 17 Rev 7/2009

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	-	For State Registrar		State of	f Maryla	nd / Dep <i>Ce</i>	artmen e <i>rtificate</i>			nd Me		giene Reg. No.	2 O I	0	00	500
Physicia		1. Decedent's Nam	_	Last)		W	2. Date of D Month					Day Year				
/Medic Examin		4a. Facility Name (	If not institution,	2 111 -	inber)	Mester	4b. City,	Town, or L	ocation of	tnió		4c. 0	4c. County of Death			
Funeral Director		5. Social Security N 213-30-	4824	6. Sex 1 → M 2 □ F		s. låst birthday 76 Yrs.	/) If Under Months	1 Year Days	Hours	Min	Date of Bir (Month, Da ) 4 / 0 2	th y, Year) 1193	3 N	Coun	lace (State of try) Carol	
Iryland show	ī	Usual Residence of 10a. State	10b. County		10c. 0	City, Town or L	ocation							10	0d. Inside C	ity Limits
Jeath with the Marylan ms 23a or 28a-f show	Funeral Director	MD 10e. Street and Nu	M/A			Ва	altimo 10f. Zip					10g. Citizen of What Country?				
th with	ralD	2607 Lc	yola S	Southway				S.A								
or ite	by Fune	11. Marital Status  1 Never Marr  3 XWidowed	ied 2 Marrie	12. Was Dece Armed Fo 1 AYes If Yes, Giv Year or D	rces? 2 ∐ No ve	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Black, W  1  Yes 2  Swo Specify: Snecify:										
permit. Pages 1 and 2 should be filed within 2 hours Department of Health and "ental Hygiene. Important: If Item 27 is marked other than " ratural", any Injury or other traumetic event, the Medical Eva once.	Completed b	(Spe	15. Decedent's cify only highest	s Education grade completed)		I (Giv	edent's Usua re kind of wor DO NOT us		16b. Kin	16b. Kind of Business/Industry						
led withii Hygiene. her than ht, the M	Comp	10th Gr	ade	College (1	-4or 5+)	į.	elting	st	eel	e Nama (i	First Middle	Bethlehem Steel				
ld be fil ental F rked ot tic ever	To Be	David Witherspoon Lucille Li										ncoln				
ld 2 sho Ith and 27 is me		19a. Informant's Name/Relationship (Type. Print) (Granddaughter) Rhonda Witherspoon  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip  700 Argonne DR., Balto., MD 21218												Code)		
t of Hea		20a. Method of Dis	position	3 □ Removal from	State	. Place of Disp cemetery, cr	oosition (Nan ematory or o	ne of ther place,	)	Dat	te	20c. Loc	cation - Ci	ty or To	wn, State	
permit. Pa Departmen Important: any Injury once.		4 ☐ Donation  21. Signature of E	5 ☐ Other (Spuneral Service L			cownsv	22. Name an	d Address	s of Facility	1/20 own	Jr. H	une	ral	Hon	e,MD ne	
9 9 E 8 8		23a, Part 1, Enter	) LETHU the disease, or o	complications that of	aused the de	aras	2140	N	Fult	on A	ve.,	Bal	timo	re,	MD Approxima	.te
Physician /Medical		shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List c (Final on	a.	each line.	ia Va	25cu								Interval Be Onset and InKOO	Death
Examiner		Sequentially list co	enditions,	b. Due to	(or as a con	equence of:	a							į	TURUO	nn_
icate be executed physician and the burial-transit	edical Examiner	Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Duw to (as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										asr				
eath certifi attending for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown										2	23d. Date of delivery Month Day Year			
n requires that the dispension to be been signed by the should be detached	þ	1 TVoc										o use contribute to the cause of death?				
The law rec cate has bee page 2 shou	Completed										24a. Was auto perfi 1 □ Yes		pri de	or to co ath?	ppsy findings mpletion of 2  No	available cause of
Physician: The ribis certificate ral director, pag	Be (	25. Was case refe examiner?		Hospital:				Othor	r: 6 #		(Check only					
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To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	1 Natural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide 4 Homicide 4 Search									d Number )	or Run	al Route Nu	mber,		
To the Hospital within 24 hours a To the Funeral L completely filled	cal Ce	29a. Certifier (Check only		g Physician: To the Examiner: On the b												(s)
To the H within 24 To the F complete	Medical	one) 29b. Signature and			ner stated.	0		c. License							Day, Year)	
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		30. Name and add	ress of person i	who completed cause	Mosyl	EN Kng		Care	e Sys	stem	Pern	Poi	4m	aryl	and al	SOR
Sta Registr		31 Date filed (Mo	1 4 201	32. F	Registrar's Sig	gnature	م		,		, ,		,	,		

DHMH 17 Rev 1/2001

Name Known TO Projecen; Witherspan, Nahaniel Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,